Health Care *for* California

Report of the Governor's Committee on Medical Aid and Health

December 1960

GOVERNOR'S COMMITTEE ON THE STUDY OF MEDICAL AID AND HEALTH

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Health Care for California

A REPORT OF
THE GOVERNOR'S COMMITTEE ON
MEDICAL AID AND HEALTH

December, 1960

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THE STUDY

In December 1959, Governor Edmund G. Brown formed the Governor's Committee on the Study of Medical Aid and Health, naming as Chairman, Doctor Roger O. Egeberg of Los Angeles. The Governor charged the Committee to:

1. Study broadly the health needs of citizens;
2. Investigate present provision for, and the cost of, health services;
3. Outline a long-range health program and its support;
4. Recommend immediate and specific action to assure a high standard of medical and health care for all Californians.

During February and March 1960, the Committee organized task forces to study four major elements of health services—organization, financing, facilities and personnel. Each task force included some Committee members and others who provided advice on the basis of their specialized knowledge and experience. However, the Committee assumes responsibility for the content of this report, recognizing that in places it does not entirely reflect the views of task force members.

In June, the Chairman of the Committee appointed four subcommittees, each composed of four or five Committee members, to study particularly: prevention of illness, diagnosis and treatment, rehabilitation and population groups with special health problems.

The six departmental consultants who served as advisors to the Committee and the task forces were responsible for developing certain of the materials included in the report.

STATE OF CALIFORNIA

EDMUND G. BROWN
Governor

GOVERNOR'S COMMITTEE ON THE STUDY OF MEDICAL AID AND HEALTH

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December 30, 1960

The Honorable Edmund G. Brown
Governor of California
Sacramento, California

Dear Governor Brown:

In response to your request of ten months ago, the following report represents the tenacious and conscientious effort of your Committee to set forth and interpret the facts concerning the health and health services of the people of California, and to make recommendations for improving them.

If it is not presumptuous, I would like to express admiration for your choice of Committee members. These nineteen men and women represent the varied interests and points of view of the people of California which are especially pertinent to health. Their individual philosophies were oriented to the broad health problems of the day. They sought factual information and worked hard at putting that information to use.

Those persons who served on the task forces appointed to advise the Committee gave generously of their time and energy. Though sometimes frustrated by lack of opportunity to participate in the decisions of the Committee, their counsel was highly valuable.

The interest and perseverance of departmental consultants assigned by you greatly assisted us. I should like also to express my gratitude to the staff assembled to carry on the continuing work of fact finding, writing, rewriting and meeting deadlines.

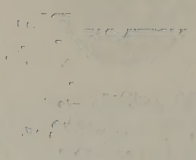
The Committee has felt that your directive made it necessary to examine all factors associated with health. They have looked at the ideal, at what may some day evolve, but have sought to make recommendations that are practical and possible to achieve in the next decade and a half - many of them within a year or two. Fifteen years may well be a far look ahead for the conservative, and it may seem only a stumbling step to the social idealist. But it can be a step long enough to represent real progress.

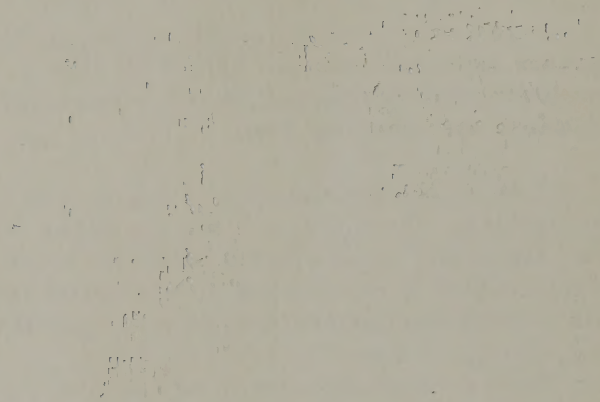
We hope this report may be the foundation for the continuing evaluation of methods of keeping our population well and of caring for the sick. This has been our aim.

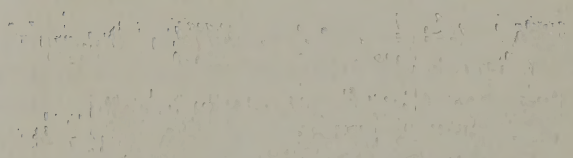
Respectfully submitted,

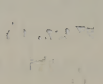
Roger O. Egeberg

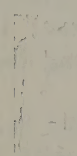
Roger O. Egeberg, M.D.
Chairman











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Chapter 1

INTRODUCTION

The evolution of the healing arts has been much like the history of mankind itself—slow development, rapid change, reversals and setbacks, and long stagnant periods. About 400 B.C., Hippocrates introduced the scientific spirit into Greek medicine and enunciated the medical ethics that have come down through the ages. But over the next four centuries medicine left little mark on history and another thousand years passed before Arabian medicine once again advanced the healing arts. During the Middle Ages medicine was at a low ebb and the "doctor's" prestige had declined, his usefulness valued between that of the cobbler and the washerman. Modern scientific medicine began in 1609 with Harvey's proof that blood circulated.

At the turn of the 20th Century, the "horse and buggy doctor", aware of how limited his medical resources were to cure the physical ills of man, gave spiritual support and love to his patients. He became, and still is, the ideal of what a healer should be.

The role of the physician changed, however, as the structure of society and the practice of medicine became more complex, particularly in the past thirty years, when more drugs and medical procedures were developed than in the entire period from the beginning of history to 1930. While patients still want their doctor to be a family friend and counselor, the days are gone when a doctor alone can give his patient all the care he needs; the doctor's time and skill and experience are no longer enough by themselves. He must routinely use laboratories, X-ray, hospitals, numerous drugs, the special competences of other doctors and allied health personnel. This dispersal of medical responsibility has tended to diffuse the personal physician-family relationship.

The use of ancillary services has so increased the cost of medical care that the physician's fee has become an ever smaller part of the patient's medical bill. Although doctors continue to donate their skills to the indigent, they need the help of the laboratory, X-ray, hospital, drugs and other health workers. The expense of these makes it impossible for him to bear all the cost of caring for the indigent as was possible when he could care for them simply by giving his time and skill and experience.

It may be relatively inexpensive to discover a procedure or a drug; developing it is more expensive, but the great cost lies in achieving its practical application to the population as a whole. For example, most "strokes" and "heart attacks" are due to clotting of blood in blood vessels. The cost of discovering that spoiled alfalfa prevented normal blood clotting was small, as was the cost of isolating and making its active principle available to patients. But the repeated tests necessary to determine proper dosage for the hundreds of thousands of patients receiving this treatment each year cost tens of millions of dollars.

Children previously doomed to a few years of invalidism before an early death now can live normal lives because of new techniques in cardiac surgery—but again at huge cost. Hundreds of further examples could be cited, such as the complex chemical procedures necessary in assessing the need for certain hormones.

With the vast increase in medical knowledge has come the need for specialization and subspecialization. Training for the various specialties continues medical education for an average of four years beyond medical school. The average specialist now goes into practice at the age of 31 after his residency training. At the beginning of the century, the average physician could start practice at the age of 21, right out of medical school.

The problems presented by the rapidly expanding amount of information, techniques and procedures related to health; the increasing population; the rising medical costs; the difficulties of meeting health manpower needs; the necessity for new equipment, new hospitals and other institutions; the desire to provide medical and surgical care for older men and women; and the need to raise the standards of care for seasonal agricultural labor, require planning if there is to be adequate supply, adequate service and appropriate distribution of health services.

These health services involve a great number and variety of people, buildings and equipment. To insure the proper kind of care at the proper time for everyone, health service organizations must work together on common problems to reach community goals. Coordination of health services can be achieved and duplication of services reduced only through planning. Continuing attention is necessary if we are to keep pace with technological progress and make the best use of available resources—people, money, buildings, equipment.

In the past 30 years, the concept of planning to many people has come to mean centralized power, strong governmental control and Federal interference in local affairs. The Committee wishes to stress a different meaning of planning. The recommendations, on the whole, are aimed at decentralization. Planning should involve more voluntary cooperation at the community level, where desire to help the aged, the indigent sick and the crippled is often born.

The Committee is confident that, presented with the facts properly developed, people will come to the right decisions. Armed with knowledge, they will reject arbitrary authority.

The Committee feels that all factors associated with health—physical environment, active prevention of illness, diagnosis and treatment of the sick, rehabilitation to as great a usefulness as is possible—are, in essence, a unity, no part of which can be neglected.

Chapter 2

POPULATION AND THE HEALTH OF CALIFORNIANS

In the mid-1930's two of the country's most distinguished demographers forecast California's 1960 population at about 8 million. But the 1960 Census counted 15.7 million persons in the State. The number of California residents has increased more than sevenfold since 1900 while that of the United States has barely doubled. In every decade since 1900, California's population has grown about three times as fast as that of the counrty as a whole.(1)

The story of California's population is by now well-known. Over the next 15 years, people will continue to pour into the State; California is one of the few large areas of the world that adds more to its population through migration than through natural increase. Between 1950 and 1960, migration accounted for almost two-thirds of its population increase.(2)

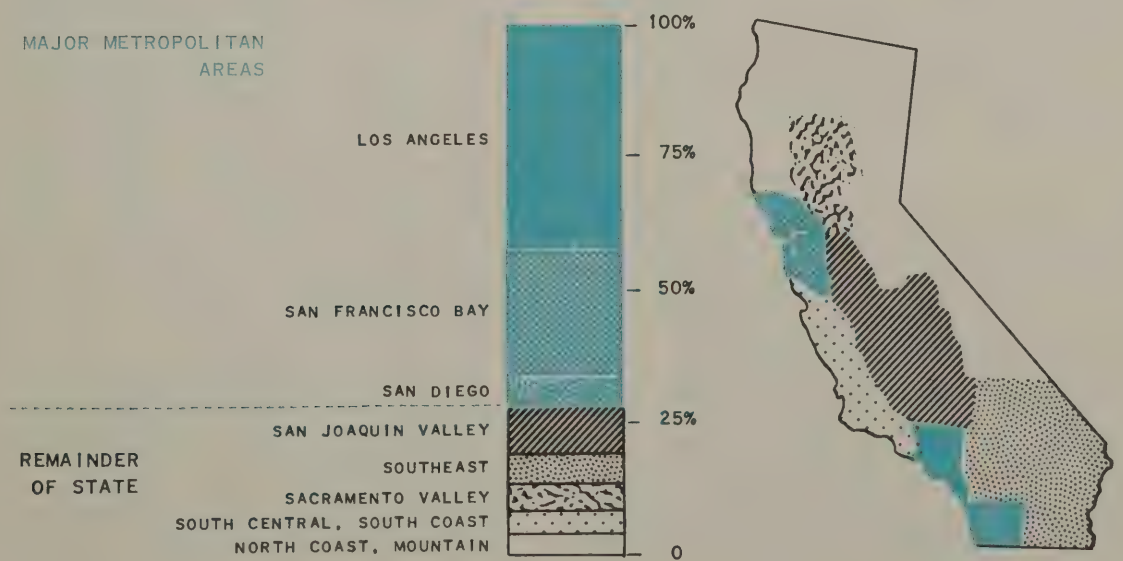
Most Californians are city people and almost three-fourths of them live in or near San Francisco, Los Angeles and San Diego. As is true of the country generally, the urban population is drifting away from the large cities to outlying—and new—neighborhoods. Thus the central cities are losing population. The effect of this city-to-suburb movement is far-reaching and carries many implications for health planning.

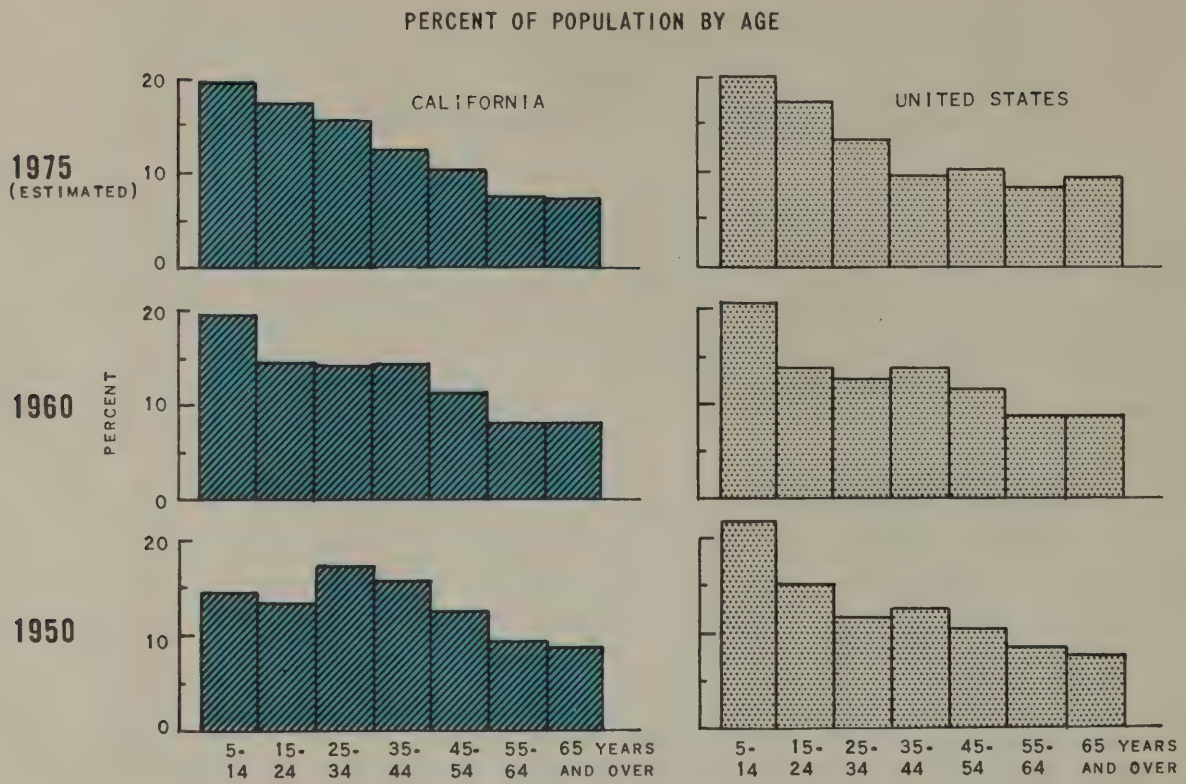
New facilities, such as hospitals, must be built to serve the increasing population in the suburbs, while facilities and services already developed in the central cities must be adjusted to changing demographic patterns.

The services, both new and expanded, that a community needs because of population growth, are related not only to numbers of people but to the nature of the population. For example, young families make up a significant proportion of those moving to the suburbs. A continuing influx of families with young children calls for different kinds of community services from those which would be needed if the new population were elderly and retired. Young families want preventive services such as immunization and medical checkups to keep their children healthy. Thus the suburbs need many pediatricians.

The drift of population from the cities to the suburbs poses problems for the cities, too. The proportion of older people rises as young families move away from established neighborhoods. The aged tend to live on limited incomes, to have a higher incidence of chronic diseases, and to require supportive community services. Medical facilities in old neighborhoods deteriorate and must be renovated at great cost. Hospitals must adapt themselves to changing health needs which reflect the changing characteristics of the neighborhood. In addition, the cities must meet the growing need for varied medical services for care of the chronically ill.

Higher education and income levels bring increased demands for health services. California has one of the highest educational levels of any state—an average of 11.6 school years for those 25 years and over, as against 9.3 years in the country as a whole.(3) In 1950, more than 8 percent of California's adults were college graduates, while the national average was 6 percent.(1,3)





California's high level of education partly reflects the relatively young age of its adult population. The State has a slightly higher proportion of residents between the ages of 15 and 44 than the country as a whole—42 percent as compared with 40 percent.(2,4) This reflects the migration of younger people coming to work in the State's growing industries.

Related in part to the youthfulness of its population and its relatively lengthy schooling, is the fact that California has a high per capita income. In 1957, per capita personal income averaged $2,543 as compared with $2,043 for the nation. Higher figures are found in only three states—Connecticut, Delaware and New York.(5)

MORTALITY RATES

A basic measure of success in meeting health problems is a downward trend in death rates. As measured by mortality rates, the health of California generally is good. Infant, maternal and total death rates are lower in the State than in the country as a whole.

Most of the decrease in mortality rates, which medical and public health workers have helped to bring about, has occurred in the younger age groups. The decrease in infant mortality, the virtual conquest of many infectious diseases, and improved general health have lengthened life, so that more people are living now to the age when chronic disease takes its toll. All the medical and public health efforts in the United States in recent decades have had little effect on death rates of persons over 45 years of age. Prevention and control of chronic diseases and the problems of aging assume more and more importance in planning for health.

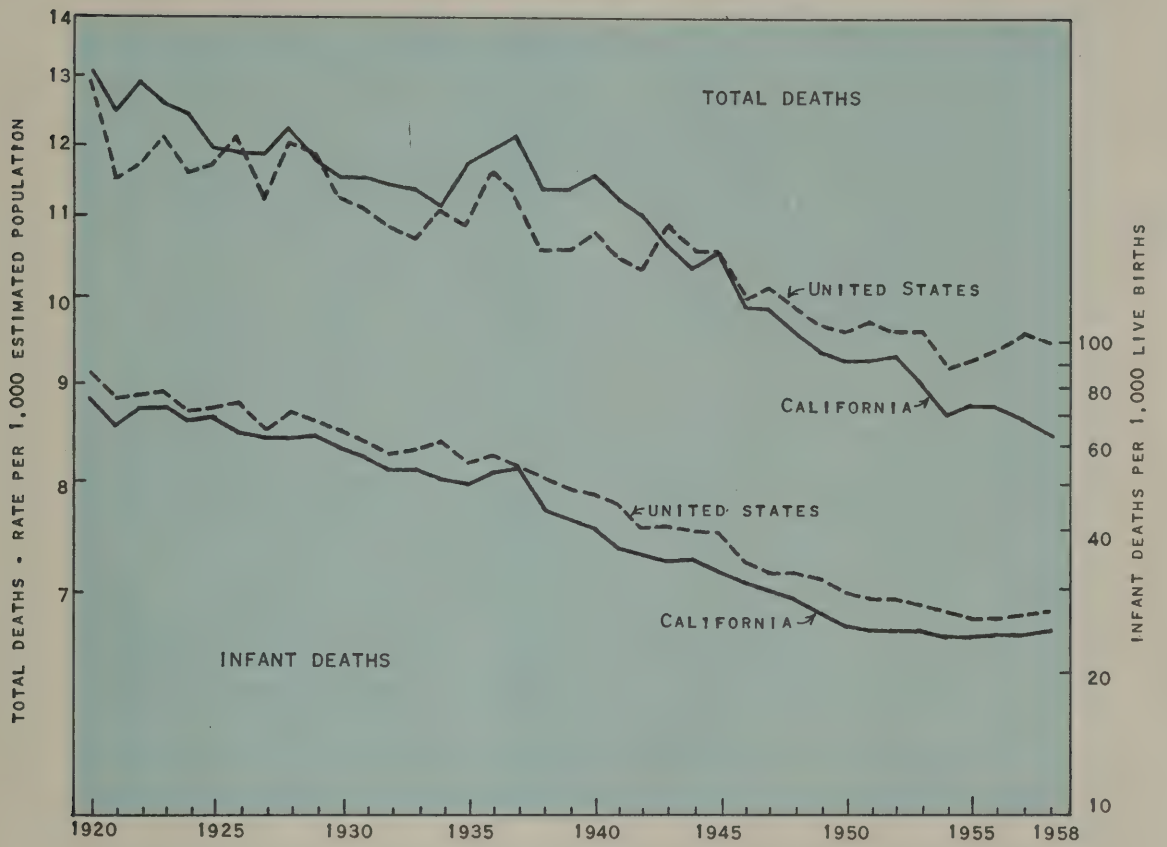
There are other special problems which must be considered. Members of some groups die younger, on the average, than others in the population. For example, the mortality rate for 1949-1951 among nonwhite children under 5 years of age was 50 percent higher than among white youngsters. For the age group 25-44, the mortality rate among nonwhites exceeded that of the white population by 63 percent.(6) There are also differences in mortality rates among married, single, widowed and divorced people. Married people have lower death rates than nonmarried people.(7) Similarly, those of lower economic status have poorer chances for a long life than do those in more favorable circumstances.

NATURE AND EXTENT OF ILLNESS

Those planning health and medical services need morbidity data (information about illnesses, accidents, impairments) as well as information about deaths. Such morbidity data have been supplied by a Statewide health survey in California, beginning in 1954-1955. The survey excludes persons in institutions.

The survey shows that, on the average, each Californian experiences about three episodes of acute illness

TOTAL AND INFANT DEATHS
California and United States, 1920-1958



each year. About half of these are due to respiratory diseases and about one-fourth are due to accidents. The disabling illnesses amounted to roughly 1.3 episodes for each person each year.

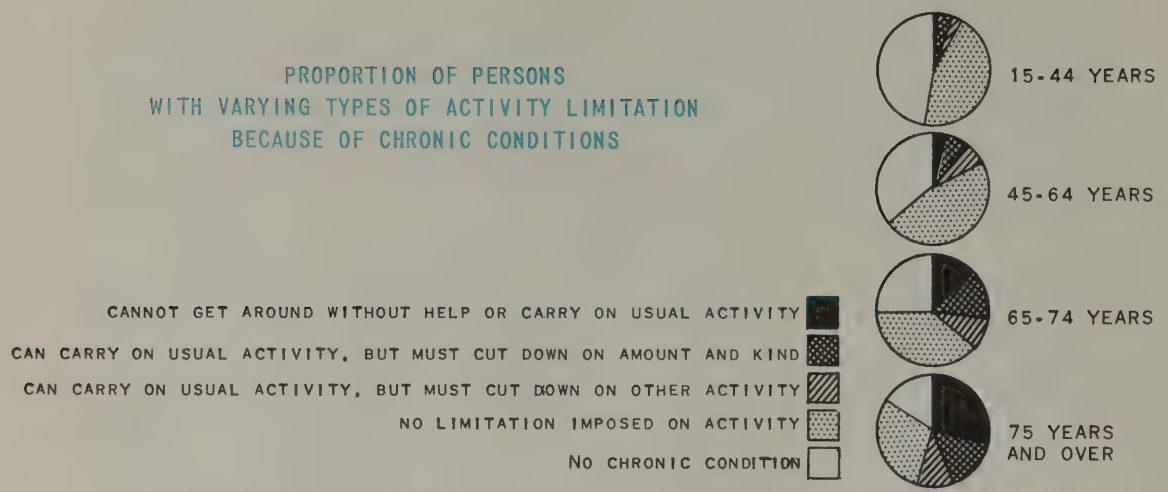
During the first year of the survey, about half of all Californians reported having at least one chronic condition. The proportion of people having a chronic condition sharply increased with age so that more than three-quarters of the persons 65 years old and over reported such conditions. Those interviewed were asked to indicate their opinion as to the degree their activities were limited by the reported conditions. The older the person, the more likely he was to be limited. After age 75, more than half considered themselves limited in their activities. Almost a third of these aged people living outside institutions stated that because of chronic conditions they could not get around without help or could not carry on their usual activities.(8,9)

Both mortality and morbidity data indicate that the persons who migrate to the State are about as healthy as persons who have lived their entire lives in California. There is no evidence that the State particularly attracts people who are in poor health.

CALIFORNIA MUST PLAN FOR ITS HEALTH NEEDS

The objective of medical care is to reduce the effects of illness and their social consequences. Sick people are often unable to work. Long illnesses frequently force them to depend on public assistance. Community services designed to keep people healthy or to restore them to health can do much to mitigate the effects of illness and its economic ravages. The proportion of the population unable to work because of illness may be taken as an index of health needs. The 1954-1955 California Health Survey disclosed 2.5 percent of the noninstitutional population over 15 years of age unable to work because of long-term illness. About half of these persons were under 62 years of age.(8)

The State is faced with the problem of developing health and community service programs where these do not exist, and to plan them for a population that will almost double in the next 15 years. California will need many more hospitals, community services and health workers than it has now. How well it plans for meeting these needs in the years ahead will greatly affect the health, happiness and welfare of its citizens.



REFERENCES

(1) Thompson, Warren S., *Growth and Changes in California's Population,* Los Angeles, The Haynes Foundation, 1955.

(2) *California's Population in 1959*, State of California, Department of Finance, August 1959.

(3) U.S. Bureau of the Census, *U.S. Census of Population: 1950 Vol. II Characteristics of Population,* Part I, U.S. Summary, Chapter C, 1953, p. 434.

(4) Zitter, Meyer and Siegel, Jacob S., *Illustrative Projections of the Population of the United States, by Age and Sex, 1960-1980*, Series P-25, No. 187, November 10, 1958.

(5) U.S. Bureau of the Census, *Statistical Abstract of the United States: 1960* (Eighty-first edition), Washington, D.C., 1960, Table 408, p. 312.

(6) *California Public Health Report*, Forty-fourth Statistical Supplement, 1951, State of California, Department of Public Health.

(7) Shurtleff, Dewey, "Mortality Among the Married", *Journal of the American Geriatrics Society*, Vol. IV, No. 7, July 1956.

(8) *Health in California*, California Health Survey, 1954-1955, State of California, Department of Public Health, 1957.

(9) *California's Older People: Their Health Problems,* State of California, Department of Public Health, 1959.

Chapter 3

ORGANIZATION AND DISTRIBUTION OF HEALTH SERVICES

The Problem

Recent changes in medical practice have been so extensive, proliferation of services so rapid, new health specialties so numerous, and the costs of all this so great that health service today has become virtually a new field; organization of its services has lagged behind its scientific progress. Those needing health care are confronted by an uncoordinated multiplicity of professions, services, agencies and institutions.

The personal services provided by California's physicians and hospitals should be consistently directed toward treatment of disease and promotion of health and readily available to all. To achieve coordinated health services, many issues of organization must be met.

Although the use of health services is increasing and the demand for care will continue to rise with population growth, rising income and educational levels, urbanization and other social and economic forces, California faces a shortage of health personnel to meet this increased demand.

Problems arising from manpower shortages are intensified by faulty geographic distribution of personnel, facilities and services which are duplicated in some places and lacking in others. Essential community health needs such as rehabilitation, organized home care, preventive services, mental health programs and nursing homes are not being met.

Federal, State, and local governments have developed a series of largely unrelated health services to meet the special problems or needs of particular groups. Government agencies offer a patchwork of overlapping and piecemeal programs. These government agencies should assume the responsibility for pulling together the diverse elements.

Three-fourths of all health care monies are provided through private, voluntary channels which both duplicate and leave gaps in service. In this sphere, government now exerts only indirect influences; but the degree to which governments will have to assume a larger future role in medical and health services depends mainly upon the effectiveness with which nongovernmental activities meet the new needs of our time.

Improved organization of services would permit the public to derive more complete benefit from the remarkable advances of medicine. The current rapid expansion of facilities and services makes it urgent that Californians plan now for more intelligent use of health resources.

The Committee recommends that:

1. *Health services be planned on a regional basis in the following manner:*

   a. *The State establish a permanent State Health Council and supporting regional health councils to develop long-range plans to coordinate and expand health services on a regional basis. The councils should be composed one-half of professional health persons and one-half of public members and be provided with full-time staff. The proposed State Health Council should eventually assume the functions of the present State Advisory Hospital Council.*

   b. *In view of the urgent need to develop a coordinated hospital system, legislation to establish regional advisory councils should be enacted immediately, as a first step toward regional planning of general health services. (Such legislation is recommended in the chapter on Hospitals of this report.)*

   c. *The State be empowered to deny and revoke licenses of hospitals and related institutions when advised by the State Health Council that such institutions have failed to comply with regional plans. This section should become operative only if the legislation proposed in the Hospitals chapter does not result in compliance with regional hospital planning.*

2. *Associations and agencies concerned with medical care encourage and support further development of forms of organization which offer*

potential for more effective medical care, including group practice; and that there be no sanctions, official or unofficial, directed against physicians because of participation in group practice.

3. *Subject to requirements for accreditation or approval for teaching purposes, physicians and other professional personnel for hospital staffs and public agencies be selected on the basis of professional competence, without regard to race, creed, political affiliation, or economic considerations.*

4. *The State and counties, in the development of their health programs, follow these organizational principles:*

   a. *Standards established by the State.*

   b. *Administration of health services (with the exception of certain types of highly specialized institutions) at the county or multi-county level, when State standards are maintained.*

   c. *Financing shared by State and local governments for those costs not met by federal funds.*

   d. *Coordination and integration of health services through "one door", i.e., a single local agency where services may be obtained or from which persons may be referred for appropriate care.*

5. *The State:*

   a. *Federate administration of its health and welfare programs in a health and welfare agency as proposed in the November 1959 report of the Governor's Committee on the Reorganization of the State Government, and include in this agency the health service aspects of vocational rehabilitation.*

   b. *Establish a council representing the fields of Social Welfare, Public Health, and Mental Health, appropriate professional groups, and the public to act in an advisory capacity to the administrator of the State Health and Welfare Agency.*

6. *The State Department of Public Health collect and analyze data necessary for development of standards in governmental and nongovernmental health services, appraise continuously the quality of care they provide, and periodically report findings to the public.*

7. *The counties establish in their public health departments:*

   a. *A medical information and referral service with an inventory of private and public health resources.*

   b. *A local health data service responsible for receiving and consolidating information necessary for the coordination of all health services available locally.*

THE NEED FOR BETTER ORGANIZATION

For the first time in history, health care has come to be considered a basic social right. A century or more ago, medical attention made little difference; doctors were virtually helpless against the agents that maimed and killed. Today's physicians have realized the age-old dream of those who practice the healing arts—they can prevent disease, cure it and in many instances repair its ravages. Because of the benefits, both actual and potential, that modern health services offer, they have become matters of great public concern. Today, the public at large expects the enormously complex technology of the healing arts to be readily available.

The dilemma of modern medicine is that its unwieldy organization impedes its effective application. The operation of health services has become vastly complicated and expensive. Servicing the nation's health is no longer a simple matter of doctors treating sick people. The responsibility for preserving and maintaining health includes concern with the purity of the air we breathe and the water we drink and the effect of the chemicals sprayed on or added to the food we eat, education of the public in personal health practices, application of technical skills in the prevention of disease, diagnosis, treatment and rehabilitation, training of specialized personnel, expansion of facilities, and the research and organization of services necessary to make all this possible.

Wide disparities in health resources exist. Certain regions are relatively well supplied; others—particularly in rural areas—lack essential services.

While the problem of providing adequate medical care is nationwide, California's stake in the problem is especially great. At a time when the entire country faces serious manpower shortages in all health occupations, California's fast-growing population will need more of all the professional services important to the health of its citizens. In little more than a decade the State will be the most heavily populated, with an estimated ten percent of the country's total population.

The demand for health services will grow for many reasons. Rising income levels and the spread of prepayment enable more people to afford better care. Rising levels of education create greater awareness of the value of medical care. New health education programs reinforce public concern with matters of personal health. The achievement of medical science increases the importance of health care as the successful treatment of a growing number of diseases and conditions becomes possible.

California should adopt a systematic approach toward solving the problem of organization and distribution of medical care in order to avoid being pressured by events into piecemeal solutions. Recent demands for improved quality of health care, better medical care for the aged, more comprehensive prepaid health coverage, and the establishment of special treatment programs are all indications of the need to plan for the best use of health resources. It is essential that the State, in cooperation with the health professions and health agencies, systematically and critically review what is being done to assure to the people health care of adequate quality and quantity.

THE PROBLEMS OF ORGANIZATION

To illustrate how the advances in medicine bring about a need for improved organization, let us suppose the patient to be a child who suffers from a severe congenital heart defect. Just a few years ago he might have died at an early age. But today his life can be saved because great numbers of highly trained people, using complicated and expensive equipment, are available and organized to carry appropriate surgery through to a successful conclusion. One break in this organizational chain could cost this child's life.

Because of the enormous expense involved (many thousands of dollars) and the complex combination of skills which can only be mustered in a large medical center, open heart surgery requires the resources of a large city for its support. Duplication of this type of surgery unit is wasteful—of scarce personnel, costly equipment and expensive hospital space. But heart surgery services should be accessible to every one in the population who needs them.

The example just given illustrates what can be done when knowledge, skill and technology are efficiently organized and put to use for the benefit of the patient. But modern medicine is not always efficiently organized.

The individual who needs medical care is often confronted by a bewildering multiplicity of people, services, agencies and institutions. He may recently have come to California and may not have a personal physician who knows him and whom he trusts. Frequently the patient tries to diagnose his own condition so that he can choose the appropriate service without wasting time and money; he may try to decide what kind of specialist or other type of practitioner he needs to treat his particular set of symptoms. But how does he know when he should go to an ophthalmologist or an optometrist, to an orthopedist or a podiatrist, to a psychiatrist or a psychologist, to a physiatrist or a physical therapist?

Depending upon his needs and a variety of other circumstances, he may have to go to many different places. He may get his poliomyelitis vaccine inoculations from a local health department, his physical examination from his private physician or a clinic, his diagnosis and treatment in a doctor's office, veterans

hospital, community or county hospital. If he needs rehabilitation he may have to deal with many different agencies and facilities. The patient's particular needs might be served by a single visit to a physician's office or they might require an efficiently organized health service system. In any case the patient should have easy access to appropriate care.

EFFECT OF SOCIAL AND ECONOMIC FORCES ON MEDICAL PRACTICE

The great differences in the way medicine is practiced today from the way it was practiced 50 years ago must be viewed against the background of profound social, economic and demographic changes in American life. Just as the family of 50 years ago reflected basic social and economic forces in American society, so today medical practice is changing dynamically in response to social forces. The idealized image of the family physician, who cared for his patients from birth to the day they died is no longer tenable. The chances are that in California neither the patient nor the physician was born and raised in the State.

The choices regarding medical care which must be made in a mobile, highly industrialized, often impersonal modern mass society are very different from the relatively simple alternatives of half a century ago. Good health has become a goal reachable through individual and community effort and not a function of mystical forces over which man has no control.

In our society of abundance, it is inevitable that goods and services which were considered luxuries in the past become the necessities of tomorrow. The increased demand for health services is tied not only to medical advances, but to new ways of paying for them.

How services can be better organized will be considered under five headings: (1) availability of services, (2) quality of care, (3) continuity of care, (4) economy of cost, and (5) efficiency in the use of resources. Good organization must take all these factors into consideration. For instance, extreme steps toward economy could work against high quality of care. Recent developments in modes of medical practice and regional planning of services offer encouraging evidence of what can be achieved through constructive approaches to the problems of organizing health services.

AVAILABILITY OF SERVICES

Health services are not actually available:

1. When they are located too far from the people who need them. Inaccessibility of health services is particularly serious in rural areas.
2. When there is a lag in applying new developments in medical care.
3. Whenever shortages of health manpower make it impossible to meet demand adequately.
4. Whenever lack of financial resources prevents low-income and needy persons from receiving certain types of care.
5. When prepayment plans which provide reasonably comprehensive coverage are too expensive for many people. Unavailability of services is as great when prepayment is too expensive as when it does not exist at all.
6. When lack of casefinding programs reduces the probability of early detection of diseases that are curable if diagnosed soon enough but which unchecked can lead to disability and premature death.

Organization of health services was simple in 1900 when its basic elements were the physician, the nurse and the patient, and when the technology supporting medical practice was also simple. Today, only the larger communities can afford to provide for every conceivable innovation in medical care. Smaller communities are either denied the more expensive equipment and services or are forced to devise local arrangements for joint use or financing. Problems of this type are most satisfactorily approached through regional planning. (This is discussed at greater length later in this chapter.)

The problem of inaccessibility of services in rural areas might be solved in part through use of mobile clinics. This possibility should be carefully studied and tested. Both Federal and State governments should support projects which test this approach as a means of strengthening civil defense and mutual-aid resources for coping with natural disasters.

In addition to distance from sources of care, obstacles to adequate health care are superstitious fear on the part of some people, delay in seeking care, misinterpretation of symptoms, and unfortunate personal experience which make some people reluctant to seek medical care. Moreover, even some health personnel do not know what services are available or how they can be used.

QUALITY OF CARE

An important objective of organizing health services is to assure a high quality of care. Quality of care rendered by a physician or a hospital can seldom be measured with exactness—even by a medical expert. However, there are a number of identifiable "elements of quality" which tend to assure good care. Professional associations, medical specialty boards, organized hospital staffs and government agencies have shown that effective standards can be maintained.

1. Proper Professional Qualifications.

   Diagnosis and treatment should be rendered only by practitioners who are qualified by knowledge, training and experience to perform a particular service.

2. Proper Procedures and Record Keeping.

   The most appropriate procedures should be used in treating a particular disease or condition, and an accurate record of treatment should be maintained, enabling others to review the procedures which have been followed in each case.

3. Professional Review.

   The work of practitioners should regularly be reviewed by others, either by direct observation or by inspection of records. In this way the knowledge and experience of colleagues support and advance the work of all. Consultations at the proper time, as well as appropriate referral of patients to specialists, are also important in assuring good care.

4. Technical Services.

   Appropriate specialized equipment should be used in diagnosis and treatment. Also, the physician should be able to call on technicians and other supporting health personnel to supply necessary specialized services.

In many California hospitals the medical staff makes use of a variety of methods in working for good quality of care, including setting of standards for appointment of new members, delineating scope of hospital privileges for individual members based on their competence, and establishing procedures for consultation in difficult cases. Several different committees function within the staff to review the level of medical performance throughout the hospital. Committees check medical records and tissue removed in the hospital for the purpose of assuring that proper standards are maintained. Membership on such a staff helps to keep the physician in touch with current medical developments, and the close contact with colleagues helps him maintain quality in his work.

Other elements related to quality of care are more intangible but also important: the physician's degree of concern for his patients and the amount of time he has available for each. In the years ahead, physicians will be faced with the responsibility for substantially larger numbers of patients. A proper patient-physician relationship is difficult to achieve when too many patients are backed up in the physician's waiting room. Haste can produce a brusque manner in the doctor and may even cause him to resort to superficial treatment. In such a setting, the patient can be discouraged from relating important personal problems to the physician. The real cause of the patient's difficulties may not be found. The preservation of sound patient-physician relationships during a period when more and more pressure will be placed on the doctor is a major problem of organization.

CONTINUITY OF CARE

Health services should include a full range of activities, starting with prevention, continuing through early detection and treatment, covering acute and convalescent care, and including rehabilitation. When these services are not properly related, the resulting breaks in care can quickly undo expensive progress achieved in earlier phases of treatment.

Fragmentation of care is an unintended but unfortunate by-product of medical specialization. The patient needs a personal physician to coordinate his care no matter how many special consultants his physician may need to call upon.

Even as the fragmentation of medical practice has produced one set of problems associated with continuity of care, another challenge to effective planning and coordination has come from the proliferation of specialized facilities and services such as specialized hospitals, nursing homes, rehabilitation centers, home care, homemaker services and new public health programs. Their functions are vital to the success of modern medical care, but their organizational relationships leave serious gaps in services.

This problem stems in part from the great emphasis placed upon institutional care by the traditional organization of health services. With the changing patterns of disease in California—notably the greatly increased prevalence and importance of chronic physical and mental illness which can be treated outside of institutions—many health authorities realize that there must be an accelerated development of other community services as well.

Californians have not yet developed enough of the community health services which people need before they enter hospitals and after they leave them. These services include home care, nursing visits, social services, rehabilitation, homemaker services and outpatient care. For example, a patient suffering from a stroke, whose life has been saved by intensive hospital care,

can deteriorate quickly after discharge from the hospital unless he receives continuing rehabilitation therapy. A patient discharged from a mental hospital may relapse if he cannot have supportive treatment in the community. The lack of community health services thus leads to unnecessary and unduly prolonged hospitalization for those who could be served more effectively and more economically in their own communities. The value of these community services is demonstrated by several pilot programs, including an organized home care program at the Los Angeles County General Hospital. Patients who would otherwise have to spend long periods in the hospital are cared for in their homes instead. The appropriate hospital and community services are brought into the patients' homes. Rehabilitation of patients discharged from mental hospitals can be facilitated through supporting services in the community, such as outpatient psychiatric care, social services, vocational placement and day- and night-hospitals.

Nursing homes have generally been isolated from the mainstream of good medical care. They need arrangements with hospitals to bring their patients the benefit of professional nursing, rehabilitation and occupational therapy. Providing this type of care is the only way to prevent some patients from sinking into the tragic and costly state of complete invalidism.

A comprehensive health record system is essential to continuity of care. The chain of accurate medical history is often broken when the patient moves from private physician to public hospital; it may be broken even when he moves to a private hospital if his physician is not a member of its attending staff. The person who moves from one city or county to another typically leaves the record of his medical past behind him, though it may have an important bearing upon a continuing or future problem. In some instances, cumulative radiation dosages being a conspicuous example, the lack of consistent procedures for comprehensive record consolidation and exchange is a real threat to individual health.

Continuity of care requires both the establishment of comprehensive medical records and the reorganization of governmental services in accordance with the "one-door" principle recommended later in this chapter. Both of these recommendations illustrate the need for a close cooperative relationship between nongovernmental and governmental health operations. Regional planning offers a feasible approach to the identification and promotion of common interests. In the normal routine of health service operations, governmental record centers might provide information exchange and referral services for nongovernmental activities, with great advantage to the public interest.

ECONOMY OF COST

There is reason to believe that comprehensive health services can be made available to virtually all Californians by means of prepayment. Provision of service-type benefits by prepayment plans enables the consumer to meet his health costs in advance, through regular payments, secure in the knowledge that he will be able to afford medical care when he needs it.

The spread of prepayment plans to larger proportions of the population depends mainly upon the progress that is made toward achieving five separate but related objectives. The hope of progress lies in planning and action by prepayment plans, medical and other health professions, and the consumer public—either separately or in combination—along the following lines:

1. Gaining Wider Public Acceptance.

   Greater interest in prepayment should be developed so that individuals and groups will be willing to invest more money in it.

2. Extending Prepayment to More Employed Persons.

   There is a need for new types of health insurance machinery in employment situations, such as in seasonal agricultural labor where prepayment is not readily available at the present time.

3. Extending Prepayment to the Unemployed.

   Prepayment should be brought within the reach of persons such as the aged and the chronically ill not currently employed. For people who cannot afford the full cost of prepayment from their own income, other sources of funds must be provided.

4. Providing a Full Range of Services.

   Prepayment should include the auxiliary health services that people want and need—early detection of disease, hospital outpatient services, home care and nursing home care—services that in many instances reduce the total cost of care.

5. Checking the Rise in Costs.

   The current rise in health costs must be counteracted through better organization of the various health services and by control over excessive costs.

Factors involved in the rising costs are discussed in Chapter 4 "Paying for Personal Health Services" and Chapter 5 "Hospitals for a Growing California". Better organization of services would greatly reduce the amount of money that otherwise would be required to finance health facilities and services.

Prepayment has profoundly affected patterns of medical organization, but its potential cannot be realized unless the voluntary prepayment plans can provide more comprehensive benefits and make coverage available to additional segments of the population. Otherwise there will be a demand for greater governmental participation in assuring medical care.

EFFICIENCY IN USE OF RESOURCES

The physician's time is one of the most precious commodities among all of the resources involved in health services. Various types of subprofessional, technical, clerical and manual assistance could relieve the physician of the work that can be properly performed by others. At every level of skill, health personnel should make maximum possible use of their highest abilities.

Many hospital administrators believe that patients should be grouped according to their degree of illness and need for care. Convalescing patients do not need all of the expensive services required by the seriously ill. If patients are grouped according to the degree of care they require, both personnel and facilities can be used more efficiently.

If hospital equipment and services are unnecessarily duplicated in a particular area, they are wasted for much of the time. As a matter of fact, some hospitals use certain of their major facilities only to a limited extent. Hospital services should be organized with a view to minimizing the overlapping of some services and the neglect of others in a community.

REGIONAL PLANNING FOR HEALTH SERVICES

Leroy E. Burney, M.D., Surgeon General of the U.S. Public Health Service has said:

> "The facilities, services and staff of a community health system should be organized to provide continuity of care at the various levels of service which the patient requires."

In California's complex array of health services, no single physician or group of physicians, no one hospital or health agency, can provide the complete range of health services which all the people of a community or region of the State may need. A few areas of the United States have shown that regional planning, conducted in a spirit of cooperation among the professions, institutions, professional schools and community agencies can solve many of the problems in organization cited in this report.

Beginning in 1936, the Bingham Associates Fund has conducted a program of regional cooperation among the hospitals in Maine and, more recently, in western Massachusetts. The New England Center Hospital in Boston, a teaching unit of Tufts University Medical School, serves as the "base" hospital. Regional hospitals are designated in Maine and western Massachusetts and serve smaller outlying community hospitals. Actual patients and their more difficult laboratory procedures or radiologic problems are referred to the regional or base hospitals; in turn, physician specialists and resident physicians from the base hospital visit and provide consultation to the regional and community hospitals. The rural hospitals may also obtain advice about general nursing, X-ray and laboratory work, medical records and hospital administration, as well as postgraduate education for medical and allied health personnel.(1)

A Regional Hospital Council, established in 1945, covers an eleven county area surrounding Rochester, New York, with about thirty hospitals. The Rochester Council's main interests have been in hospital administration. It provides a joint purchasing plan for its members and conducts a central credit and collecting service. Educational institutes are held periodically on topics of interest and guides have been developed for use of the hospitals.(1)

REGIONAL ORGANIZATION OF HEALTH SERVICES

In view of the rapid growth of California's cities and suburbs and the continuing isolation of certain rural communities, it has become essential to coordinate health services on a regional basis. As in the case of organization of physicians' services, California has an opportunity to pioneer in planning hospitals and related health facilities and services on a regional basis. Coordination must bring the many health professions, facilities and services into an effective relationship with the population which uses health services.

Physicians, dentists, nurses and other professional health workers, hospitals and related facilities, medical schools, health departments, voluntary health organizations—all these and other elements in modern health services find it necessary to plan their activities in relation to the total community resources. Joint purchasing of drugs and supplies, central maintenance services

among groups of hospitals and continuing education of physicians are a few examples of regional cooperative activities. No single pattern would be suitable for all regions of California and flexibility is desirable, but it is becoming increasingly apparent that regional planning of health services should be undertaken promptly.

The regional approach enables the persons most concerned to participate in the decisions. It also affords proper recognition of the particular problems and resources of the area. Responsibility for planning the overall private and public programs for the medical care and health of a region should be fixed in a regional health council of persons drawn from that region. Every organization that plays a part in providing health care should be represented—health professions, health facilities, medical schools, local health councils, voluntary health associations and governmental units. Half the members should represent the consumer public.

In seeking better patterns for health services, the Committee believes that many different approaches are possible and that experimentation should be encouraged. This may involve varied ways of paying for health services, e.g., direct payment, prepayment plans, government medical care programs and private philanthropy, and various means of providing service such as group practice, individual practice, hospital care and home care.

Regional Health Councils should be established:

1. To collect pertinent data and conduct studies which would point up any duplication and gaps in the provision of comprehensive health services for the region.
2. To study health manpower needs for the region.
3. To develop a regional health plan in order to assure an orderly development of health services in the region.
4. To promote coordination of the activities of the health professions, facilities and services in the region so that continuity of patient care at the several levels of service is accomplished.
5. To make recommendations to the State Health Council.

The State Health Council and its staff would have the responsibility for: (1) developing Statewide plans for comprehensive health services; (2) coordinating the activities of the Regional Health Councils.

The functions of the Advisory Hospital Council in the State Department of Public Health would eventually be assumed by the State Health Council.

The Committee recommends that health services be planned on a regional basis in the following manner:

a. The State establish a permanent State Health Council and supporting regional health councils to develop long-range plans to coordinate and expand health services on a regional basis. The councils should be composed one-half of professional health persons and one-half of public members and be provided with fulltime staff. The proposed State Health Council should eventually assume the functions of the present State Advisory Hospital Council.

b. In view of the urgent need to develop a coordinated hospital system, legislation to establish regional advisory councils should be enacted immediately, as a first step toward regional planning of general health services. (Such legislation is recommended in the chapter on Hospitals of this report.)

c. The State be empowered to deny and revoke licenses of hospitals and related institutions when advised by the State Health Council that such institutions have failed to comply with regional plans. This section should become operative only if the legislation proposed in the Hospitals chapter does not result in compliance with regional hospital planning.

FORMS OF MEDICAL PRACTICE

THE CHANGING PHYSICIAN

Medical education, training and methods of practice have been greatly affected by a variety of factors, including specialization. The proportion of graduates from American medical schools in fulltime specialty practice has risen from 30.4 percent for the 1930 graduates to 74.1 percent for 1945 graduates.(2) In 1959, 52 percent of all physicians in private practice in California were specialists.(3,4)

Equally dramatic has been the shift in methods of practice. Three-fourths of the 1935 graduates practiced individually in 1955—but less than half of the 1945 class of graduates did so.(2)

The young person beginning a career in medicine today has different expectations from the physician of 50 years ago. Not only is his education more exacting and much longer, but he has additional pressures and responsibilities. In line with the younger age of marriage of the general population, 60 percent of the 1959 graduating medical students were married.(5) The cost of education is high, and a majority

of medical students are substantially in debt by the time they graduate. Debts are further increased by lengthy periods of hospital training, usually at very modest salaries.

During the years of his medical school and hospital intern and residency training, a physician works closely with other physicians in a setting that provides stimulation for professional growth. He may desire to maintain such an atmosphere after entering practice, particularly when his practice is specialized. This means he must have time for postgraduate training and time to acquaint himself with the newest developments in his field. Moreover, the young physician, along with other professional persons, is showing more interest in leisure time to spend with his family, vacations, and some measure of security against periods of illness and retirement.

California physicians, particularly those who serve as family doctors, may have difficulty in realizing some of these expectations in the years ahead, when demand for medical care is rising and the State's physician-population ratio is declining. If the demand is to be met, the physician's work week will grow longer, unless his productivity is increased through improved organization of health services.

MAJOR FORMS OF PRACTICE

The various forms of medical practice—the organizational mechanisms by means of which physicians render care to patients—may be grouped under five major headings, each representing in a general way a more complex organization than the preceding form.

1. Individual practice.
2. Individual physicians making joint use of buildings and services.
3. Partnership practice.
4. Group practice.
5. Medical center or medical school practice.

The simplest form of organization is represented by the individual practitioner who practices independently with little or no help from supporting personnel. The other organizational extreme is medical center practice where physicians work closely with one another in one geographical location, fully supported by the widest range of allied personnel, services and equipment.

EVALUATING THE FORMS OF PRACTICE

The various forms of medical practice can be evaluated in relation to their capacity to provide efficiently and economically for certain factors or elements important to good medical care:

1. The extent to which physicians work together —through conferences, consultations and referrals.
2. The number of quality controls that can be provided—in other words, the degree to which the professional advantages of the hospital medical-staff type of organization can be achieved.
3. The range of specialized services and equipment which are important to continuity of care and which can be offered in one location which is close at hand.
4. The extent to which proper use is made of allied health personnel.

A highly skilled individual practitioner can provide the best possible care to many of his patients without reference to medical resources outside his office, but the quality of his care is diminished when he is unwilling or unable to refer patients whose medical needs require special attention that he cannot provide.

It is generally true that the proximity and availability of other physicians increases from one level of organization to the next. Thus, arranging for consultation and referral with colleagues is easier for a physician who is located in a large medical office building than it is for an isolated practitioner.

A somewhat similar relationship exists in connection with the accessibility of specialized services and equipment. The larger the number of physicians located in one area who make use of the same specialized services and equipment, the more elaborate and extensive these aids can be. In the larger group practices and in medical centers, these services may be performed and the equipment operated by other persons for the convenience of the physician.

The extent to which the physician is able to use allied health personnel is also roughly dependent upon the number of physicians who are located in one place and the closeness with which they work together. If a sufficient number of skilled assistants—nurses, technicians and aides—are available to the physician, he is able to concentrate his time and attention on the tasks which only a physician can perform, leaving other functions to persons specifically trained for them. A proper division of duties can produce important benefits in cost and quality of care. In the same way, appropriate use of both administrative and clerical personnel can free the doctor of paper work.

The danger of bigness is its tendency to produce an impersonal approach. Each patient needs to have one physician assume the responsibility for coordinating his care as he moves from one specialist or service to another. Usually, he also wants at least one physician to show personal interest in him as an individual, not just as a medical problem. This kind of attention has long been identified with the individual physician, but is in danger of being lost under the pressure of the increasing number of patients who must be seen by the average physician. Special effort is needed both to establish a proper patient-physician relationship in the larger forms of practice and also to retain it in individual practice.

GROUP PRACTICE

In considering the existing forms of organization, the Committee believes that group practice constitutes a particularly effective form of organization, especially for the years ahead. This does not mean that group practice is necessarily superior to other forms in every regard, or superior in a general way at the present time. Certainly there is evidence of shortcomings as well as achievement, but group practice has demonstrated that it offers a positive mechanism for achieving high quality of care, effective continuity of care, economy to consumers and efficient use of facilities, services and personnel.

TRENDS IN GROUP PRACTICE IN CALIFORNIA

STUDY	YEAR	NUMBER OF GROUPS	NUMBER OF PHYSICIANS IN GROUP PRACTICE			PHYSICIANS IN GROUP PRACTICE AS PERCENT OF PHYSICIANS IN PRIVATE PRACTICE	
			Total	Full-Time	Part-Time	Total	Full-time
Hunt-Goldstein (PHS)	1946	26	398	315	83		
Weinerman	1950	52	849	634	215	6.7[a]	5.0[a]
AMA	1959	106	1,634	na	na		
Pomrinse (PHS)	1960	109	1,813	1,555	258	10.6[b]	9.1[b]

na Not available

[a] Calculated on the basis of 12,719 physicians in private practice in California in 1949.

[b] Calculated on the basis of 17,069 physicians in private practice in California in 1959.

Source: Hunt, G. H., and Goldstein, M. D., Medical Group Practice in the United States. Public Health Service Publication No. 77, 1951.
Weinerman, E. R., Medical Group Practice in California. California Medicine 76:383-388, (June) 1952.
American Medical Association, Council on Medical Service, Listing of Group Practices in the United States, (November) 1959.
Public Health Service, Preliminary unpublished data from 1960 Public Health Service Survey of Group Practice.

There is a definite trend toward development of the more complex types of medical-practice organization, including group practice. Group practice coupled with prepayment may become the predominant means of providing medical care in the future. These highly important trends toward greater degrees of organization should be directed in such a way that effective care will result. The leadership and guidance of the medical profession are needed to assure achievement of this goal.

There are four times as many medical groups in California in 1960 as there were in 1946, and almost five times as many physicians practicing fulltime in group practice.

There have been instances in California, some very recent, where sanctions have been imposed on prepayment group-practice physicians by other members of the profession even though organized medicine has officially endorsed group practice.(6) Also, hospital staff appointments have been withheld from group practice physicians.

Physicians engaged in group practice must be permitted to function in the medical community to the extent that is justified by their individual competence. Restrictions other than those related to professional ability are contrary to the public interest and work against high quality of medical care.

The Committee recommends that associations and agencies concerned with medical care encourage and support further development of forms of organization which offer potential for more effective medical care, including group practice, and that there be no sanctions, official or unofficial, directed against physicians because of participation in group practice.

The Committee recommends that subject to requirements for accreditation or approval for teaching purposes, physicians and other professional personnel for hospital staffs and public agencies be selected on the basis of professional competence, without regard to race, creed, political affiliation, or economic considerations.

ORGANIZATIONS THAT COMBINE FINANCING AND PROVISION OF HEALTH SERVICES

California has long been a leader in experimenting with new organizational forms of practice in combination with experimental methods of paying for them. Several voluntary plans that combine the financing and provision of health services for their members have been operating in California and elsewhere for a number of years. Their successes and failures provide the experience needed for new systems of organization.

The Ross-Loos Medical Group, a partnership of physicians established in 1929, provides a wide range of prepaid medical services to members, with hospitalization now covered by insurance. In 1932, a group of hospitals in Sacramento jointly organized a community-wide prepayment program. This was followed in 1936 by the organization of the Hospital Service of California (Blue Cross), by the Alameda County Medical Association and seven voluntary hospitals in that county. Originally offering service only in Alameda County, the organization extended its operations throughout Northern California. In 1937, the Hospital Service of Southern California was organized. In 1939, the California Medical Association organized the California Physicians Service (Blue Shield), the first statewide physician-sponsored medical plan in the United States.

The Kaiser Foundation Health Plan became a community-wide program in California in 1945, growing out of the programs originally organized by the Kaiser industries to provide medical care for workers during construction of the Grand Coulee Dam in eastern Washington in the late 1930's, and for shipyard employees at the yards in Richmond, California, during World War II. Its subscribers are eligible for a wide range of medical services included as hospital benefits.

One of the most important recent developments in the concept of prepayment plans has been the organization of foundations for medical care, found largely in the central valley regions of the State, the San Joaquin Foundation being the primary example. These plans are sponsored by local medical societies, and they represent a significant departure from more traditional types of plans because they endeavor to establish certainty of coverage for members by means of fixed fee schedules for medical procedures which participating physicians have agreed to accept as full payment. The foundations have pioneered the approach of using group average incomes as the guide for setting fees rather than the incomes of individual patients.

The Windsor Medical Services Plan of Ontario, Canada, and the Health Insurance Plan of Greater New York (HIP) are other examples of systems that provide an extensive range of cost-controlled services to subscribers. The Windsor Plan has demonstrated that a fee-for-service system is compatible with full prepaid coverage. Wide benefits are made available at reasonable cost because physicians have accepted a fixed fee schedule; safeguards against unjustified use of services are employed.(7) Some of the organizations mentioned above have exercised quality as well as cost control over the services rendered.

ORGANIZATION OF GOVERNMENTAL HEALTH SERVICES

It has been estimated that approximately one quarter of California's annual expenditures for health services is paid from governmental funds, either by direct provision of services or by purchase of services from private sources—physicians, dentists, hospitals and others. The Federal Government spends $125 million annually in California, mainly for the care of veterans.(8) The State government allocates $260 million annually for health services (excluding capital outlay), half of which is for the care of the mentally ill and the mentally retarded.(9) Local governments appropriate $195 million annually, primarily for the support of county hospitals.(10)

Medical care for the indigent or medically indigent has been traditionally a responsibility of county governments in California. Care may be given at county hospitals, provided by county-designated physicians, or purchased by county welfare departments.

The State government has assumed primary responsibility for the care of the mentally ill. This constitutes by far the largest medical program directly administered by the State, which has developed twenty different medical programs in ten State agencies, about half of which were started since 1940. According to a report of the State's Legislative Analyst:

> ". . . . There is no well-defined specific policy goal for all the medical care sponsored by the State. Programs have been established from time to time to meet individual needs. As these programs have expanded and other programs have been created, services tend to overlap, eligibility varies, fiscal subventions or administrative patterns tend to provide varying incentives or even deterrents to local government support of medical care programs. The individual patient faced with a given medical problem may be confronted with a choice of programs or a lack of service depending on county of residence, type of disease and particular eligibility. He may be liable for repayment, payment by relatives, or he may receive care free. He may get minimum service, partial

service or maximum complete quality care. These differences may exist within a single program or among the total of programs.

As government offers more medical care to more people, it becomes necessary to clarify the State's goals in medical care and to coordinate its own approaches to medical care to coordinate with the federal and local programs. The substantial rise in medical costs accentuates the necessity. Incorporation of State medical programs under one department would solve some of the administrative control and coordinating problems found in medical care. Many other important problems would still require further legislative review and corrective action."(12)

The present wide range of programs finds the Federal, State and local governments all providing direct medical services and all operating subvention or contract programs. The Federal programs are generally directed to categories of people (veterans, military personnel, Indians). State programs are aimed at particular diseases (tuberculosis, mental illness, crippled children). Most county-administered programs are organized on the basis of need (indigency, public assistance recipients).

DETERMINATION FOR ELIGIBILITY FOR PUBLIC MEDICAL CARE

Eligibility standards for public medical care in California are far from uniform. Each of the fifty-eight counties sets its own eligibility requirements for county hospital services. A California citizen may be eligible for hospital care in a particular county, but ineligible if he moves to another with different eligibility standards. Variations exist even among the State-controlled programs. Certain State agencies administer their own tests for eligibility, while others leave the determination of eligibility to the counties.

SCOPE OF SERVICES UNDER PUBLIC MEDICAL PROGRAMS

Many public health service programs are not comprehensive in scope of services; some are set up in such a way as to make continuity of care difficult. The Public Assistance Medical Care program has used its funds to pay for services given by private practitioners in their own offices. Where hospitalization is needed, the same patients who received office services under the medical care program are likely to be admitted for inpatient care to county hospitals. Here another set of doctors takes over responsibility, often without reference to what has previously been done in physicians' offices.

The Crippled Children Services for many years have concentrated on the correction of orthopedic and congenital handicaps through surgical means. "Medical" conditions—those correctable by nonsurgical means—have only recently been added to the list of eligible conditions.

Although many county hospitals in California provide a high level of medical care, some do not. There are serious gaps in diagnostic and outpatient services. In general, psychiatric care, rehabilitation and organized home care are either inadequate or not provided.

FINANCING OF PUBLIC MEDICAL PROGRAMS

Great variations in financing exist among programs in which State subventions or subsidies are administered by local agencies. In the Short-Doyle Mental Health Program, the State subvenes 50 percent of the costs to local governmental units. In the Crippled Children Services program, approximately two-thirds of the funds are from the State and one-third from the counties. In the Public Assistance Medical Care program, no county funds are involved, although county welfare departments have administrative responsibility. Similarly, funds for the operation of the pilot treatment clinics in the Alcoholic Rehabilitation program are contributed by the State.

ADMINISTRATION OF PUBLIC MEDICAL PROGRAMS

California's public medical programs are administered in various ways. Some, such as the Vocational Rehabilitation Service and State mental hospitals, are operated entirely by the State. Others are operated by counties or cities under varying degrees of State supervision. Still others, notably county hospitals, are operated solely by the counties.

FEE SCHEDULES

Increasingly, government is purchasing health service rather than providing it directly. This practice requires that the responsible agency negotiate a fee schedule with the supplier of the service. The fee schedules for similar or identical medical procedures vary among the several State agencies that purchase care, although an Interdepartmental Medical Fee Committee has recently been formed to resolve some of these variations.

Repayment provisions vary as widely as eligibility standards—from asking the patient's relatives to assist in payment if they can, to using liens against the patient's property or estate.

The Committee recommends that the State and counties, in the development of their health programs, follow these organizational principles:

1. ***Standards established by the State.***
2. ***Administration of health services (with the exception of certain types of highly specialized institutions) at the county or multicounty level, when State standards are maintained.***
3. ***Financing shared by State and local governments, for those costs not met by federal funds.***

4. *Coordination and integration of health services through "one door", i.e., a single local agency where services may be obtained or from which persons may be referred for appropriate care.*

Application of these principles would result in decentralization of principal State health programs, which then would be administered by local governments. The State, aided by local advice, would develop and maintain standards for all State and local programs, including the county hospitals, and would share with local governments the responsibility for financing these programs.

The Committee believes that this partnership between the State and local governments would establish a complementary responsibility for more effective health programs than either partner could provide alone. This organizational arrangement would provide for a check on each partner by the other, as well as a basis for stimulating program development.

Two well-established programs—Tuberculosis Sanatoria and Crippled Children Services—operate on the basis of Statewide standards, local administration and shared financing. These programs provide a pattern that could be adapted to others, both new and existing.

STANDARDS ESTABLISHED BY THE STATE, WITH LOCAL ADVICE

Standards for administration of health programs should be established and maintained by the State with consideration for community differences. There should be periodic review of local operations to insure that standards are being met. The State should make technical consultant services available to the counties on request, so that local administration can be continually made more effective.

State standards assure establishment of uniform minimum eligibility requirements and scope of services throughout the State. Standards set minimums for professional competence and criteria for the organization of local health services. Whenever possible, standards should be suggested as broad guides which would allow for local flexibility, rather than specified in detail by State regulations.

State standards also establish the quality of care to be purchased by government. For example, the State Crippled Children Services developed standards and requirements for cardiac surgery which must be met by hospitals and physicians who participate in the program. Government agencies should become fully responsible for setting the standards for services they purchase. Public tax funds should be spent only for services known to be of high quality.

ADMINISTRATION OF HEALTH SERVICES

If State programs are decentralized and administered by county or multicounty agencies, they should be placed under local units large enough to assure effective and economical administration. Local administrations should be required to maintain State standards. The trend toward professional management is already evident in both city and county government. Thirty-eight counties now have county administrative officers and all but a very small portion of California's population is now served by local health officers with formal training and experience in health administration.

The combination of local administration with Statewide standards permits the counties to concentrate on developing effective administration, patterned to meet local needs, and frees the State agencies from direct operational responsibilities—giving them opportunity to emphasize research, experimentation and program development.

SHARED STATE-LOCAL FINANCING

Costs for locally administered, State subvened health programs should be shared between State and counties. Extra funds should be allotted by the State to those areas which are unable to support services at State standards. Local administration should make for greater interest in health programs among local authorities and citizens and could stimulate local interest in planning.

"ONE DOOR" FOR LOCAL GOVERNMENTAL HEALTH SERVICES

In local governmental health services, continuity of the patient's care is difficult to achieve because programs are administered by several different agencies. In most counties there is very little administrative coordination of governmental health programs. However, some have begun to coordinate their programs. In San Mateo County, for example, a unique federated department includes welfare, county hospital, tuberculosis and public health programs. A few counties combine public health and hospital programs.

There is a need to achieve greater uniformity of eligibility requirements in the various programs, and

to reduce existing gaps and eliminate duplications in the local administration of health services. The development of a central mechanism for exchange of medical information among the various programs is essential if continuity of care is to be attained. The creation of a single agency, "one door", through which people can obtain services and referrals to appropriate agencies would facilitate coordination of local health programs and would also tend to insure equality and accessibility of services.

FEDERATION OF STATE HEALTH AND WELFARE PROGRAMS

The Governor's Committee on Reorganization of State Government has recommended the creation of a Health and Welfare Agency which would functionally combine the existing Departments of Social Welfare, Public Health, Mental Hygiene and Veterans' Affairs. These departments would be "brought together under one agency in order to open many avenues for closer cooperation and coordination of activities".

The Governor's Committee on the Study of Medical Aid and Health supports this recommendation, but urges the inclusion in this agency of the health service aspects of vocational rehabilitation (now in the Department of Education) as a necessary step toward unified administration of all major health responsibilities of the State.

This health and welfare agency would provide the organizational framework for improving the efficiency and economy of health administration throughout the State. An advisory council with professional and public representation should be appointed to assist the administration in guiding and coordinating the State and local program activities of the agency, and to bring an imaginative approach to the broad community health problems faced by the State.

The Committee recommends that the State:

a. Federate administration of its health and welfare programs in a Health and Welfare Agency as proposed in the November 1959 Report of the Governor's Committee on the Reorganization of the State Government, and include in this agency the health service aspects of vocational rehabilitation.

b. Establish a council representing the fields of social welfare, public health, and mental health; appropriate professional groups; and the public to act in an advisory capacity to the administrator of the State Health and Welfare Agency.

HEALTH DATA

Adequate health information is necessary if health services are to keep pace with the rapid technological progress of medicine. To deal with organizational problems of duplication and waste, a better method of collecting, maintaining, and using health records and allied data must be developed. A State agency should set standards and procedures to guide the counties in receiving, using and disseminating medical information.

The committee recommends that the State Department of Public Health collect and analyze data necessary for development of standards in governmental and nongovernmental health services, appraise continually the quality of care they provide, and periodically report findings to the public.

INCREASING RESPONSIBILITY OF LOCAL HEALTH DEPARTMENTS

A comprehensive and currently maintained inventory of all private and public health resources should be centrally located in each county. The use of such an inventory is indispensable to facilitate the ready referral of patients for needed care through "one-door". A similar inventory compiled from county reports and located in a State agency would show existing gaps, duplication and overlaps of locally available services.

Effective personal health services require continuity of care whether that care is received in the office, clinic or hospital. Medical care is "case centered", and when the patient receives treatment from various sources of services, the exchange of medical information becomes indispensable. For a fully efficient exchange of an individual patient's medical records, there should be a centrally located reservoir of information for receiving, storing and transmitting these records. The information needed for the administration and coordination of governmental health services would then be readily available to the providers of service.

The Committee recommends that counties establish in their public health departments:

a. A medical information and referral service with an inventory of private and public health resources.

b. A local health-data service responsible for receiving and consolidating information that is necessary for the coordination of all locally available health services.

REFERENCES

(1) Roemer, M. I., Morris, R. C., "Hospital Regionalization in Perspective", *Public Health Reports*, Vol. 74, No. 10, October 1959, pp. 916-922.
(2) Weiskotten, H. G., Altenderfer, M. E., "Trends in Medical Practice". *Journal of Medical Education*, 31:1-92, Part II, July 1956.
(3) American Medical Association (unpublished data).
(4) American Osteopathic Association (unpublished data).
(5) Association of American Medical Colleges, Questionnaire Survey.
(6) "Findings, Conclusions, and Recommendations of the Commission on Medical Care Plans", *J.A.M.A.*, Vol. 169, No. 3, Part II, January 17, 1956.
(7) Darsky, B. J., Sinai, N., Axelrod, S. J., *Comprehensive Medical Services Under Voluntary Health Insurance*, Cambridge, Massachusetts, Howard University Press, 1958.
(8) Direct correspondence with various Federal Agencies.
(9) State of California, Budget for fiscal year July 1, 1960—June 30, 1961.
(10) Direct correspondence and reports of various State agencies.
(11) *Administrative and Fiscal Policy Problems in California Public Medical Care Programs*, prepared by Legislative Analyst, December 8, 1959.

Chapter 4

PAYING FOR PERSONAL HEALTH SERVICES

The Problem

In recent years, the rising cost of health care has become a matter of increasing public concern. These costs have become burdensome to many, in particular the low income groups, the aged, the chronically ill, and the disabled. Although the people of California each year spend ever-larger sums for health services, not enough money is spent to provide for comprehensive services, including community programs such as prevention, organized home care and rehabilitation.

Some of the high costs of health care result from wasteful and inefficient practices such as needless duplication of hospitals, programs and services. Drug costs are high, partly because of some industry practices not in the public interest. Some of the excessive cost of health care stems from poor planning, such as government spending for health services which is piecemeal, overlapping and largely uncoordinated. New methods of paying for health services, developed over the past thirty years, have led to certain abuses which divert some of the medical care dollar to nonmedical outlays.

In the years ahead, the people of California will need to spend much more on health services if they are to keep pace with (a) the demands for more comprehensive care, (b) expected rising unit costs, and (c) the expanding population. But more money spent on medical care without efficient and economical organization of services would accelerate inflation of costs.

To insure comprehensive care of high quality at reasonable cost, additional ways to pay for health services and better methods of organization must be developed. The Committee believes that the most practical way to meet the cost of personal health care is through prepayment, the enormous potential of which has been amply demonstrated in the past 15 years. Nonprofit prepayment organizations and commercial insurance companies have made giant strides toward extending prepayment to large numbers of people. But before the best possibilities of prepaid medicine can be fully realized, many problems must be solved.

Under present forms of prepayment some groups—the aged, the disabled, the chronically ill, the needy, those in minority groups, those in certain rural areas—often find it difficult, and sometimes impossible, to get coverage. Even for those already covered, prepayment meets only about one-third of the total cost of their health care. Many services, particularly preventive services, are not included, and the extent and scope of benefits vary widely. A major limitation of most prepayment plans is that they do not exert control over the cost and quality of the services they pay for.

The Committee recommends that:

As Long-Range Goals

1. *Comprehensive health care of high quality be available to everyone in the State, and necessary financing to assure this result be provided from individual, private or public sources.*
2. *Prepayment for health services be extended to cover substantially the entire population of California.*
3. *Prepayment benefits be in the form of services or substantially cover the cost of services.*
4. *Means be found through prepayment to cover the cost of medical services after retirement.*
5. *Changes in the extension and financing of health services should proceed in a carefully timed and coordinated manner.*

As Immediate Objectives

6. *The State establish a system of standards for grading policies for prepayment of health services according to the type and extent of benefits and exclusions, and require that the grade of each policy be clearly indicated on its face; and that standards be reviewed periodically and policies falling below the lowest standard not be approved for sale.*
7. *Group policy holders when leaving the group have the right to convert to individual*

policies without evidence of insurability or lapse of coverage, and that converted policies provide for essentially the same benefits, exclusions and premiums as that of the group.

8. *Prepayment organizations renew and strengthen the principle of community rating in order that the maximum numbers of the community may be served fairly and adequately.*
9. *Individual health policies be noncancellable and renewable without premium increase unless all premiums and/or benefits in that insurance class are changed.*
10. *The State approve only those individual health policies providing benefits reasonable in relation to the premium charged, and that each prepayment organization each year be required to notify subscribers or policy holders of its claims experience.*
11. *Reimbursements for prepaid health services received by an individual be no more than the actual cost of services rendered.*[1]
12. *Half the membership of governing boards of nonprofit prepayment organizations be representative of community and consumer groups.*
13. *The State extend its premium rate regulating authority to all organizations providing for prepayment of health services, including commercial insurance, nonprofit corporations, medical partnerships and others.*[2]
14. *In order to broaden the prepayment of health services as recommended by this Committee, new sources of revenue, both private (individual and organized) and public be found, and that to this end a special objective study be initiated, to be aimed particularly at the problem of financing a minimum of prepaid health service for substantially the entire population as well as the problem of financing State supported programs other than prepaid health services.*
15. *The State, in cooperation with private and professional organizations, continuously appraise the cost and quality of health services and periodically report findings to the public, and that the State fix responsibility for this activity in a single agency.*
16. *Manufacturers of drugs for sale or use exclusively in California be required to certify that the drugs meet federal standards for drugs of the same type or class sold in interstate commerce, and that such certification be filed with the State Department of Public Health which will be responsible for enforcement.*
17. *The State repeal fair trade laws regulating prices of prescription drugs.*
18. *The State repeal the sales tax on prescription medicines and appliances.*
19. *The State provide funds for demonstration projects designed to develop more economical and effective patterns of health care.*
20. *The State exert leadership in the field of voluntary prepayment for health care by setting up a program for State employees which follows the prepayment principles set forth in this report.*
    a. *The State develop specifications for a prepaid comprehensive health program.*
    b. *A State agency that can provide leadership and technical skills in the health and prepayment fields and continuously eval-*

DISSENTING COMMENT

[1] *"I do not concur with this recommendation. If carried into effect, this recommendation would prevent the individual patient from collecting indemnity on health benefits for which he has paid in cases of double or overlapping coverage. Individuals are allowed to buy overlapping and double coverage, and the benefits therefrom belong to the individual. Also, the administrative problems implicit in this suggestion are great."*

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[2] *"Too often state insurance premium rate regulations can develop into carrier-controlled price fixing. I would approve this recommendation if there were ways of assuring that there would be competition in premium rates, and continued opportunity for health insurance, non-profit, and other health prepayment programs, to develop new ways of lowering costs and administrative expenses of paying for medical care."*

Stephen I. Zetterberg

uate the cost and quality of medical care provided, be made responsible for the program.

c. *Retired employees and their dependents be enrolled at the same premium rates and benefit coverages as active employees, and that local public jurisdictions be permitted to enroll their employees in the State health plan.*

COSTS OF HEALTH CARE RISING

The public is becoming more and more concerned about the high cost of medical care. Over the past twenty years, an increasing share of the national income, both from public and private sources, has been spent for health services—from 5.1 percent of the national income in 1940 to 6.2 percent in 1958.(1,2) California's annual total health bill is over two billion dollars.

Although the nation is spending more than six times the amount spent in 1929 for health care—about $22.7 billion in 1958, of which $17.3 billion come from private sources and $5.4 billion from governmental sources—it is not spending enough to meet all our health needs.(1)

Although America's doctors and other health workers are among the most knowledgeable and skilled to be found anywhere, the great potentials of modern medicine are still not being fully realized. Not enough use is being made of the techniques of preventive medicine, including early diagnosis and treatment; many who need psychiatric care cannot afford it nor are enough such services available; and too little is spent for rehabilitation.

The Committee believes that the people of California, regardless of income, age, sex or condition of health, should have all needed health services made available to them. But it also feels that unless health services are organized for maximum efficiency and economy, more money spent on medical care would accelerate the inflation of medical care costs.

CALIFORNIA HEALTH COSTS HIGHER THAN NATION'S

Although the rate of increase of health costs in California is about the same as for the nation as a whole, actual health costs to Californians are higher than elsewhere.(3,4) For example, the average daily charge by voluntary hospitals[1] in California in 1959, including room and board and other hospital services was $41.80; in the nation $29.49. The average cost of an average hospital stay in California was $259, the sixth highest of any state in the nation.(5)

There are many reasons for higher health care costs in California:

Hospital costs are high partly because of inefficient use of services and manpower, and also because of the over-building in metropolitan areas of small proprietary institutions which are uneconomical to operate and which duplicate services.

A much greater proportion of prepayment for health service is handled by commercial insurance companies in California than is true elsewhere in the country. These companies' charges for nonmedical costs – administration, advertising, sales commissions – are substantially larger than those of nonprofit prepayment organizations. They return to the insured a lower proportion of the premium dollar as benefits.

Total health care costs tend to be higher the more services are used and Californians use health services more than other Americans. On the average, they see doctors and dentists more often.(6,7)

California's health care costs are also higher because they reflect the generally higher wages and salaries in the State. The wages and salaries of health workers are likely to play an even more important part in future health care costs as their traditionally low wages rise until they approach those of comparable nonmedical occupations.

QUALITY AND COST OF DRUGS

At present, many identical or largely similar drugs are sold under various trade names, each owned by a different pharmaceutical manufacturer. This multiplicity of names for a single drug creates confusion. As a result, doctors are sometimes unable to interpret prescriptions written by other doctors, and are frequently suspected by their patients of not keeping current when they confess to unfamiliarity with a particular new brand name.

The problem of trade names is complicated by the rapid rate at which new drugs, many of unproved value, are placed on the market. Between 1948-1955 more than 3,000 new prescription drugs, each with an average life span of two to five years, were offered for sale. Some were new, but others were only new combinations or new dosages for drugs already on the market. In 1940, fewer than 100 drugs were introduced; in 1957 about 400.(8)

There is widespread feeling that drug prices could be reduced for the public if drugs were prescribed under generic rather than brand names. Exponents of this procedure raise the point that certainly the same drugs sold under different brand names vary in price and that pharmacists would be free to fill prescriptions with the more economical brands of drugs if physicians would prescribe in generic terms. It is also true that the Public Assistance Medical Care Program of the Department of Social Welfare already encourages physicians to write generic prescriptions for welfare patients, specifically in order to reduce high drug

[1] Nonprofit, nongovernmental hospitals.

costs. Unfortunately, however, there are several current conditions which militate against recommending the universal use of generic names in prescriptions.

Responsibility for determining the safety and purity of drug products sold in interstate commerce rests with the Federal Food and Drug Administration. In recent years the FDA has been unable to keep its testing and inspection program abreast of the accelerating production of new drugs, primarily because Congress has failed to appropriate sufficient funds for this purpose. Thus, many drugs are sold and consumed without having been inspected or tested. Moreover, the FDA lacks authority to determine the effectiveness of new drugs. Those manufactured and sold exclusively in California are not subject even to inspection and testing under the Federal law, though they are subject to inspection under California Pure Drugs Act. In the absence of adequate inspection and testing, doctors are often reluctant to use generic names, preferring to rely on brand name products of whose quality they feel confident.

Therefore, the Committee believes that since Congress has not appropriated enough funds to assure adequate testing and inspection of drugs, it would be unwise to advocate universal use of generic names as a method of reducing the cost of drugs. Another way to reduce these costs would be to repeal the State's fair trade law regulating the minimum price of drugs. The competition among the large pharmaceutical manufacturers would then tend to lower the cost of drugs to the patient in California.

The Committee recommends that manufacturers of drugs for sale or use exclusively in California be required to certify that the drugs meet Federal standards for drugs of the same type or class sold in interstate commerce, and that such certification be filed with the State Department of Public Health which will be responsible for enforcement.

The Committee recommends that the State repeal fair trade laws regulating prices of prescription drugs.

The Committee recommends that the State repeal the sales tax on prescription medicines and appliances.

MEASURING INCREASES IN HEALTH CARE COSTS

The Consumer Price Index which estimates changes in the costs of all goods and services rose 71 percent between 1939 and 1949, while medical care costs rose only 43 percent. However, between 1949 and 1959, when the costs of all goods and services rose only 22 percent, medical care costs rose 45 percent. For the entire twenty-year period (1939-1959), the medical care component increased by 108 percent compared with 110 percent for all goods and services, and the *medical* services component rose by 122 percent, compared with 81 percent for *all* services during the same period.

The larger increase in the cost of medical care services, compared with the cost of all services, is almost entirely the result of a 317 percent increase in hospital room rates between 1939 and 1959. Most other medical care components of the Index have not risen significantly faster than other nonhealth services.

Since each of the many segments which comprise the medical care component is represented by only a

PERCENT INCREASE IN PRICE INDEX FOR SELECTED ITEMS
UNITED STATES, 1939-1959
(1947-1949 = 100)

ITEM	PERCENT INCREASE		
	1939-1949	1949-1959	1939-1959
All Goods and Services	71.4	22.4	109.8
All Services	30.7	38.7	81.3
Medical Care	43.4	44.9	107.7
Medical care services	48.4	49.4	121.7
Hospital room rates	120.4	89.2	317.0
Physicians' fees	37.4	38.1	89.8
General practitioners' fees	37.4	40.7	93.3
Surgeons' fees	37.6	22.3	68.2
Dentists' fees	48.9	28.9	92.0
Optometric examinations and eye glasses	26.4	14.0	44.0
Group hospitalization	-	86.2[a]	-
Prescriptions and drugs	23.0	19.4	46.8

[a] Index base, December 1952 = 100. Increase covers 8 year period, 1951-1959.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index.

few items in the computation of the entire component in the Consumer Price Index, question has arisen as to its validity as a measure of changes in medical costs. (9) At present, hospital costs are computed solely on the basis of room rates, although as much as half of the total hospital bill is often for services other than room and board.(10) Changes in drug prices are estimated on the basis of a few prescriptions and proprietary medicines and do not include many expensive new items, such as antibiotics (except penicillin), tranquilizers and cortico-steroids. Physicians' fees are estimated from a sample of routine consultations, too small to be representative. And some factors, such as changes in the quality and quantity of medical care, new services and new methods of payment, which contribute to the high costs of medical care are not considered at all.

Better ways to measure changes in the cost of medical care should be developed. Information about new services, changes in the use and quality of existing services, technological developments and scientific discoveries, and increased specialization, must be collected continuously if a more valid picture of changes in medical costs is to emerge.

The Committee recommends that the State, in cooperation with private and professional organizations, continuously appraise the cost and quality of health services and periodically report findings to the public; and that the State fix responsibility for this activity in a single agency.

BETTER METHODS OF PAYING FOR HEALTH CARE NEEDED

Awareness of the importance of health care is unquestionably increasing. And the rapid growth of prepayment in the last twenty years clearly indicates public acceptance of this method for meeting the costs of medical services. However, the percentage of people covered by prepaid services in California is smaller than that in the country as a whole—65 percent as against 72 percent.(11) (At the end of 1957, 90 percent of the New York State population had some form of prepayment.)(12) Although some progress has been made toward providing health insurance for the unprotected, many groups are still inadequately covered.

Currently, about one-quarter of California's insured population is covered by Blue Cross and Blue Shield plans. This is a considerably lower proportion than in the country as a whole and in other large states. Nationally, in 1958 about 45 percent of people with prepayment plans were covered by Blue Cross or Blue Shield;(13) in 1956 in New York, 67 percent;(14) and in 1957 in Pennsylvania, 58 percent.(15)

The number of Californians covered by various prepayment plans in 1960 is shown in the table.

The Committee supports the principle that everyone should have access to comprehensive health services of high quality. By eliminating economic barriers to medical care, California would be well on its way toward this goal. California should immediately take the steps necessary to reach this objective.

As long range goals:

NUMBER AND PERCENT OF CALIFORNIANS COVERED BY VARIOUS PREPAYMENT PLANS, 1960

	NUMBER	PERCENT
Population	15,600,000	-
Net covered	10,088,000	-
Duplicated policies[1]	759,000	-
Total policies	10,847,000	100
Blue Cross (Northern California)	828,000	8
Blue Cross (Southern California)	982,000	9
Blue Shield (California Physicians' Service)	779,000	7
Kaiser Foundation Health Plan	631,000	6
Ross-Loos Medical Group (Los Angeles)	128,000	1
Other Independent Plans	182,000	2
Commercial Insurance (estimated)[2]	7,317,000	67

[1] Based on 7 percent duplication of coverage estimated by the Health Insurance Institute.

[2] Based on predicted 2 percent annual increase over 1958 estimate of Health Insurance Association of America.

Source: Correspondence with prepayment organizations, Health Insurance Associations of America and others.

The Committee recommends that comprehensive care of high quality be available to everyone in the State, and necessary financing to assure this result be provided from individual, private or public sources.

The Committee recommends that prepayment for health services be extended to cover substantially the entire population of California.

PROBLEMS OF PREPAYMENT

Prepayment for health services involves two major principles:

1. The sharing of the risk by distributing the total cost of health care equally among a large group, regardless of how much or how little service any one member of the group may use.
2. The defraying of the cost of health care in advance and by installment.

Not all health plans embody both principles. Most plans, particularly those sold by commercial insurance companies, embody primarily the first principle by writing the kind of insurance which was developed for such hazards as fire and automobile collision. The purpose of this kind of insurance is to indemnify, that is, to reimburse the insured person for a loss resulting from an unusual or unexpected occurrence.

To limit their liability, insurance companies tend to indemnify for expenses for medical care rather than provide health services directly or by contract. This casualty insurance point of view also encourages "major medical", or "catastrophic", insurance which requires the individual to pay a substantial portion of initial medical charges—e.g., the first $200 of medical costs—after which the insurance company pays 75 or 80 percent of the remaining charges up to a fixed maximum of perhaps $5,000. Insurance companies assert that requiring the insured to pay a portion of their medical expenses prevents abuse of services. But these "deductibles" which have to be paid in addition to premiums may act as a deterrent to the seeking of that early medical attention which could prevent serious illness.

Casualty insurance is basically designed to indemnify for damage from major and unpredictable events such as fire and accident. People suffer many predictable illnesses (some minor in nature; some which prove to be minor only if treated early), and have predictable needs for maintaining health (e.g., periodic physical and dental examination, eye refractions and immunizations). The medical services necessary to them at those times should not be excluded from their prepaid health plans.

Plans which provide direct services, such as Kaiser Foundation Health Plan and the Ross-Loos Medical Group, and to a lesser extent, those that provide contractual services, such as Blue Cross and Blue Shield, differ from those which operate primarily on casualty insurance principles. The former are based on the desirability of furnishing health services rather than reimbursing for medical expenses, Although they vary in the extent to which they are able or willing to furnish these services, their plans are constructed to meet this need.

In addition, the direct service plans attempt to provide a wide range of health services to their members, including services for maintaining health and for treatment of minor illnesses. These services are not usually provided and are rarely paid for by commercially-insured plans.

Because people's needs and tastes differ, it is of course desirable that the public have a choice from among a variety of prepayment plans, ranging from direct service to cash reimbursement. It should be said, however, that it is extremely difficult for cash indemnity plans to provide for integrated health services, or to set up cost and quality controls of purchased health service. Insurance companies and health and welfare plan administrators rarely consult with the medical profession to determine the benefits that should properly be covered by their policies. Cash indemnity insurance leads to many problems which makes it an unnecessarily costly method of paying for health services.

Major medical insurance encourages excessive charges by physicians because usually no limit is placed on the charges. Indemnity surgical schedules lead to inflation of costs because they permit higher charges for services than might be charged were the patient not insured. Commercial health insurance for individuals and families is usually sold by salesmen paid by commission, who frequently have little knowledge of health problems or incentive to consider the special needs of consumers. Some insurance companies divert excessive amounts of their policy holders' premiums to overhead, sales expenses and commissions in relation to the benefits provided.

The Committee recommends that reimbursements for prepaid health services received by an individual be no more than the actual cost of services rendered.

The recommendation above is for immediate action. As a long-range goal:

The Committee recommends that prepayment benefits be in the form of services or substantially cover the cost of services.

PREPAYMENT BENEFITS VARY WIDELY

The amount and type of benefits provided by prepayment plans range from limited coverage for hospital costs to relatively comprehensive coverage which includes hospital care, physicians' services in the home,

office and hospital, and diagnostic X-ray and laboratory services. Service plans generally pay for a ward room for a specified period of time, part of the physicians fees for care in the hospital, and often for care in the doctor's office and at home. As already noted, the commercial insurance policy holder generally pays his own hospital and medical bills (unless he assigns payment to the vendor) and is later reimbursed for part of, or rarely, the entire cost.

PREPAYMENT MEETS ONE-THIRD OF COST

Typically, comprehensive prepayment plans cover about one-third of the subscriber's total health bill. Depending upon the particular prepayment plan, the proportion of health service costs covered varies widely among plans.(16) For example, a survey of hospital allowances provided for nearly 700,000 workers and their dependents through large collectively bargained health and welfare plans in California in 1957, disclosed that only 40 percent of the workers and their dependents were entitled to fully paid ward room accommodations. The remaining 60 percent were entitled to fixed dollar benefits which averaged $12.69 for workers and $11.42 for dependents, when the average daily ward room charges were $21.50 in Los Angeles and $23.12 in San Francisco.(17,4) Similarly, other allowances were often considerably less than actual charges.

Many health services and illnesses are excluded from coverage under most plans. Even "comprehensive" plans which make virtually no extra charges when furnishing services which are covered, usually do not pay for dental services, outpatient psychiatric care, long-term institutional care, corrective appliances and eyeglasses. Drugs and medicines are usually paid for only while the patient is in the hospital. Conditions which existed before coverage are sometimes excluded, as well as certain other disabilities, such as venereal diseases, self-inflicted injuries and illnesses, alcoholism and drug addiction. In addition, preventive health services, such as periodic physical examinations, immunizations and well-baby care often are not covered except by comprehensive plans. A few other plans have begun to furnish some of these services on an experimental basis.

UNEQUAL PREPAYMENT CHARGES FOR HEALTH SERVICES

Such factors as age, sex and income composition of a population affect the rate at which health services are used. Some groups use health services more heavily than others: for example, the elderly utilize hospitals more than two and a half times as much as younger people, and see physicians about 60 percent more often,(18) and women use physician services to a greater extent than do men.(19)

Blue Cross, Blue Shield and group practice prepayment plans, such as the Kaiser Plan originally established charges for all subscribers according to the average cost of the services used by a large cross-section of the population. Under such a system, older persons who normally need more extensive medical care make the same prepayment as younger persons. When prepayment costs are borne equally by all members, this is known as "community rating", which is distinct from the "experience rating" used by insurance companies and other prepayment organizations.

When insurance companies entered the field of prepayment in force and "experience-rated" their groups, a major problem was created. This kind of insurance offers cheaper rates to groups composed largely of "low risks", people less likely to make extensive use of health services, and places the burden of higher payments on groups which have a relatively high proportion of older persons and women.

By thus nullifying the principle of spreading the risk equally among the largest number of people, experience rating raises the cost of prepayment for precisely those people who have the greatest need for services. Ultimately, this kind of rating would reduce groups to smaller and smaller segments, with the end result that medical payments would again become an individual matter.

A few of the larger plans which provide direct health services, such as the Kaiser Foundation Health Plan, have maintained charges to subscribers substantially on a community-rating basis, although Blue Cross, Blue Shield and a number of other service plans have been compelled to switch to experience rating in order to meet the competition from the commercial companies.

Understandably, many health and welfare funds and employers, caught in the squeeze between having limited amounts to spend for health services and the rising cost of medical care, have been buying experience-rated plans and continually demanding more favorable rates. About 1,200,000 workers plus their dependents are covered under collectively bargained health plans in California, most of which are experience-rated.(20) Whether community-rated plans can continue to withstand competitive pressure from commercial insurance companies is a serious question.

Continuation of experience rating is not in the public interest because its progressive effect is to raise health insurance costs beyond the reach of an increasingly larger portion of the population. The aged, the chronically ill, the unemployed and others who are considered "high risks" are able to cover little if any of their health costs through this kind of prepayment and many become medically indigent and public charges.

Unless prepayment plans community-rate their membership, it will be virtually impossible to make comprehensive prepaid health services available to every Californian regardless of income, age, sex or condition of health.

The Committee recommends that prepayment organizations renew and strengthen the principle of community rating in order that the maximum numbers of the community may be served fairly and adequately.

The essence of community rating is to charge each group the same for the same benefits. The Committee believes that in order to assure this the State would have to fix the rate to be charged.

The Committee recommends that the State extend its premium rate regulating authority to all organizations providing for prepayment of health services, including commercial insurance, nonprofit corporations, medical partnerships and others.

PROTECTION NEEDED WHEN LEAVING THE GROUP

Members of groups covered by health plans face serious problems when they leave the group; in the majority of cases their insurance is automatically terminated. In 1959 only about 33 percent of group policyholders with commercial insurance throughout the United States were entitled to convert to individual policies on termination of group status.(21) In some instances where the withdrawing member is permitted to switch to another plan, this is often with greatly reduced benefits at a higher premium. Rarely can he continue his insurance with the same protection at the same cost when he leaves the group. This works a particular hardship on people who are retiring from employment because of age or disability.

The New York State Insurance Department recently studied voluntary health insurance for the aged.(14) As a result, New York now requires continued coverage at the option of the insured after termination of employment or at retirement.

The Committee recommends that group policyholders, when leaving the group, have the right to convert to individual policies without evidence of insurability or lapse of coverage, and that converted polices provide for essentially the same benefits, exclusions and premiums as that of the group.

Individual health insurance policyholders should be similarly protected.

The Committee recommends that individual health policies be noncancellable and renewable without premium increase unless all premiums and/or benefits in that insurance class are changed.

The recommendations above are for immediate action. As a long-range goal:

The Committee recommends that means be found through prepayment to cover the cost of medical services after retirement.

BENEFITS ARE LOW

Prepayment can serve its full purpose only by providing benefits which are meaningful as to kind and quantity. These should include hospital room and board and other hospital services; physicians' and surgeons' services, both in and out of the hospital; diagnostic, X-ray and laboratory services both in and out of the hospital; and perhaps other relevant services.

While the California Insurance Code gives authority to the Insurance Commissioners to set minimums for health insurance benefits, these have been set so low as to be completely unrealistic. For example, the present hospital room and board insurance minimum allowance is $3 per day, despite a statute which requires that benefits be of "real economic value to the insured".(22) The Committee believes that minimums should be raised immediately to carry out the express intent of the statute.

STANDARDS OF UNIFORMITY NEEDED FOR PREPAYMENT

Prepayment plans should be required by law to meet standards. Graded standards for health insurance policies should be established which specify:

1. The type of benefits covered by each grade of policy. For example, the lowest grade might include only hospital benefits; the highest grade all health services.
2. The extent and amount of the benefits covered by each grade of policy. For example, the lowest grade might include hospital room and board benefits of $10 per day for 31 days; the highest grade semiprivate room rates for 365 days.

No policy should be approved for sale which falls below the lowest grade. Standards should be reviewed periodically to bring them into line with changing costs and changing patterns of medical care.

The Committee recommends that the State establish a system of standards for grading policies for prepayment of health services according to the type and extent of benefits and exclusions, and require that the grade of each policy be clearly indicated on its face; and that standards be reviewed

PERCENT OF INCOME PAID OUT IN BENEFITS
CALIFORNIA, 1955–1959

	1955	1956	1957	1958	1959
Blue Cross (Northern California)					
Group	91	96	95	88	87
Individual	95	90	97	83	85
Blue Cross (Southern California)					
Group	92	98	96	94	89
Individual	77	79	88	85	83
California Physicians' Service					
Group	na	91	94	89	84
Individual	na	79	82	83	80
Insurance Companies					
Group	81	85	88	90	na
Individual	44	45	45	44	na

na Not available.

Source: Direct correspondence with Blue Cross and California Physicians' Service.
State of California, Insurance Commissioners' Annual Reports, 1955–1958.

periodically and policies falling below the lowest standard not be approved for sale.

SOME PREPAYMENT DOLLARS USED FOR NONMEDICAL COSTS

Prepayment cannot be a fully effective means for easing the payment of health costs so long as a substantial portion of the prepayment dollar is diverted to nonmedical expenses.

The proportion of prepayment plan income returned in benefits is known as the "loss ratio," and this varies considerably among different plans. Over four years (1955-1958), service plans in California paid out more than 90 cents on every prepayment dollar for benefits to their members. During the same period, commercial insurance companies returned 76 cents for every prepayment dollar (on both group and individual policies combined and including cash payments for loss of income).(23)

In the case of commercial insurance companies, the amount kept back also includes profit and 2.35 percent of the premiums collected for taxes.

BENEFIT PAYMENTS ON GROUP INSURANCE

On group insurance, the average yearly loss ratios of Blue Cross and Blue Shield and the average for all commercial insurance companies ranges between 81 and 98 percent. Many commercial companies write a large volume of group insurance with loss ratios remaining consistently above 90 percent. However, some companies writing group insurance consistently pay out less than 70 cents of every prepayment dollar for benefits. Thus, over the last four years (1955-1958), seven percent—$72,000,000—of the total volume of group health insurance written by commercial insurance companies returned less than 70 cents of the prepayment dollar in benefits. For example, company A wrote $32,000,000 worth of group insurance during this period and paid out less than $21,000,000, or 64 cents on every dollar of premium. Company B wrote almost $10,000,000 worth of group insurance and returned a little over $5,000,000, or 55 cents on the dollar. Several companies reporting group insurance for the first time in 1957 or 1958 showed exceptionally low loss ratios.(23)

BENEFIT PAYMENTS ON INDIVIDUAL INSURANCE

Of the total amount of prepayment written by Blue Cross and Blue Shield in 1958, 26.5 percent or $30,578,089 was issued to individuals or families not members of groups.(24) In 1958 the commercial insurance companies wrote slightly over $100,000,000 of individual and family health insurance (25 percent of their total disability insurance volume including loss of income policies[1]).(23) Since insurance issued to individuals rather than groups must be solicited and collected on an individual basis, it involves more administration and other overhead costs, which accounts in part for its relative expensiveness over group insurance. Nevertheless, Blue Cross and Blue Shield paid

[1] Accident and health, noncancellable, and hospital and medical. Accident and health and noncancellable categories include loss of income insurance.

out 84 cents on every dollar on individual policies in 1958 while the commercial insurance companies paid out only 44 cents.

While some commercial companies pay out more than 50 cents of the prepayment dollar from individual policies, many others pay out much less. Of a total of $133,000,000 worth of *individual hospital and medical insurance* written in California by commercial companies during the four-year period of 1955-1958, almost $61,000,000, or 46 cents on the dollar was paid in benefits. Company C wrote $23,000,000 worth of individual hospital and medical insurance and returned $8,000,000—or 35 cents on every dollar. Company D wrote $5,000,000 and returned $1,500,000—or 30 cents on every dollar.(23)

Since Blue Cross, Blue Shield and some insurance companies have demonstrated that fair value can be returned on both group and individual prepayment, they should be used as the yardstick for measuring whether benefits paid are reasonable in relation to premiums charged. Statutory controls are needed to insure the public a fair return on the money it spends for prepayment.

STANDARDS OF REASONABLENESS

State regulation of insurance has long been accepted in the United States. Such regulation, now recognized as necessary and proper, checks on the licensing, qualifications, financial solvency of insurers, and also on contracts and practices which might victimize the insured.(25) However, although premium rates for most other forms of insurance are closely regulated, health insurance premium rates (other than for credit accident and sickness insurance) are not regulated at all except in New York and Pennsylvania.

In several states, Blue Cross and Blue Shield recently became subjects of special inquiry by insurance commissioners and legislatures. As the costs of health care rise, there will be increasing public pressure to regulate all prepayment plans more closely. California regulates the retention charges of Blue Cross. On the other hand, the State of California does not regulate California Physicians' Service, Kaiser Foundation Health Plan or other independent direct service plans. The California Insurance Commissioner lacks authority to regulate health insurance rates or loss ratios either for these groups or for commercial insurance companies. (Such type of authority has been granted to insurance commissioners in many states.) As of 1954, seventeen states required that approval of individual or family group accident and sickness insurance be withdrawn "if the benefits provided therein are unreasonable in relation to the premium charged". However, these laws do not specify standards for judging reasonableness.(25)

The Committee recommends that the State approve only those individual health policies providing benefits reasonable in relation to the premium charged, and that each prepayment organization each year be required to notify subscribers or policy holders of its claims experience.

PREPAYMENT PLANS SHOULD ESTABLISH COST AND QUALITY CONTROLS

It has been suggested that prepayment plans themselves assume active responsibility for upgrading standards of quality, since more than 127 million Americans in 1959 had some form of prepayment.(11) Consumer groups (unions, employers, insurance companies), as well as the health professions, have a large stake in developing administrative mechanisms for maintaining the quality of care inside and outside hospitals.

Voluntary measures have already been undertaken in some instances. In New York the Health Insurance Plan of Greater New York has established a medical control board which sets standards relating to education, group organization, facilities and equipment of member groups.(26) Windsor Medical Services of Windsor, Ontario, denies payment to participating physicians when its physician review board decides that service given was unnecessary.(27) In Michigan, Blue Cross has established standards for new hospitals and makes payments only to hospitals which meet the standards.(28) In New York, it has been recommended that benefits be paid only to hospitals accredited by the Joint Commission, and that unaccredited hospitals be given three years to gain accreditation, with a further extension of two years if evidence of compliance is shown.(29) In California, the San Joaquin Foundation for Medical Care, sponsored by the San Joaquin County Medical Society, has set up controls which extend the principle of the internal medical audit to physicians' offices and home care.(30) It has been suggested that medical audit committees should be jointly sponsored by the Blue Shield Plans and the medical societies.

In Philadelphia, Blue Cross in an attempt to reduce overuse of hospitals, provides outpatient diagnostic benefits and visiting nurse service after hospitalization.(15) The Philadelphia County Medical Society has set up a Physicians' Review Board to investigate unnecessary admissions, overuse of ancillary services and needlessly prolonged hospital stays.

However, most prepayment organizations do not concern themselves with the quality of care for which they pay. Consumers should be included on governing boards of prepayment plans to stimulate these organizations to play a more active role in working with the professions in upgrading the quality of care and to develop more concern for cost.

The Committee recommends that half the membership of governing boards of nonprofit prepayment organizations be representative of community and consumer groups.

SOURCES OF ADDITIONAL FUNDS FOR PREPAYMENT

Prepayment for health services should cover as many people as possible and cover the broadest range of services. That is, prepayment plans should be comprehensive in scope. Most prepayment plans not only fall short of these goals but also are too expensive for many of the people who most need health care.

If the public is to benefit fully from the revolutionary scientific advances of the past thirty years, much more money must be spent on health care. The method of payment is as important as the sums spent. In order to achieve the long-range goals set forth in this report, new ways of raising money for health care must be found.

The Committee hopes that the following suggestions will be studied and evaluated by a body charged with the responsibility for weighing the alternatives, investigating their costs and practicality, and arriving at workable solutions.

Additional funds needed to broaden prepayment programs could come from one or several of the following sources:

1. Through increased use of individual prepayment. Effective control and supervision of prepayment plans would bring the cost of prepayment within reach of larger numbers of people and encourage the purchase of more and better health coverage.
2. Through increases in collectively bargained plans, unilateral management and employees plans and other group plans. Prepayment furnished through such means is not just a "fringe" benefit, some trivial or "extra", but an important form of compensation. There has been a notable trend toward continuing coverage for workers after retirement from employment. If all plans were to provide paid-up coverage for retired workers, they would go far toward alleviating health care problems of the aged in the future.
3. Through the use of the State general fund to provide prepayment for those segments of the population unable or ineligible to secure their own health insurance—the unemployed, the disabled, the aged, etc.
4. Through the use of the Federal Social Security mechanism.
5. Through the use of special taxes, all or a portion of which could be earmarked for the purpose of purchasing health care. Examples of these are property taxes, sales taxes, income taxes, employer and employee payroll taxes. While many different taxes might be enumerated, most of them have already been committed for the support of government at its various levels. The primary source of revenue for the operation of the Federal Government is, of course, the income tax. Although the State also makes use of the income tax as a source of revenue, it is questionable whether it could provide additional funds for health services. Use of the property tax as a source of revenue is confined to city and county governments, is not available for use by the State, and is already committed.
6. A special case of the use of the employee payroll tax would be the expansion of California's present Unemployment Compensation Disability Program. In presenting an analysis of this method for raising additional funds, the Committee wishes to emphasize that it did not make a decision to endorse or not endorse this alternative. Some members of the Committee felt that this was one concrete approach to the problem of raising additional funds. This proposal, along with others, should be studied ex-

TAXABLE WAGE LIMIT	INCOME FROM PRESENT 1 PERCENT	INCOME FROM ADDITIONAL 1 PERCENT	TOTAL INCOME	ANNUAL AMOUNT PER WORKER[1]	MONTHLY AMOUNT PER WORKER[1]
	(In millions of dollars)				
Present $ 3,600	$ 23.9[a]	$149.2	$173.1	$46.16	$3.85
Increase to 6,000	83.2	208.5	291.7	77.79	6.48
Increase to 7,200	100.2	225.5	325.7	86.85	7.24
Increase to 10,000	108.8	234.1	342.9	91.44	7.62

[1] Based on 1959 average covered employment of 3,750,000.

[a] That portion of tax presently devoted to health benefits. Total current income from the one percent tax is $149.2 million, of which the bulk goes for cash payments for loss of wages.

tensively by a group of experts in the field. Consequently, the following outline is submitted.

UCD PROPOSAL

Expansion of the Unemployment Compensation Disability Program could provide a health service plan for eligible California workers comparable to those provided under some collective bargaining agreements and others supported by employers. Such a plan should include at least 120 days of hospital ward room accommodation, ancillary hospital services, surgical and medical services in the hospital, and outpatient diagnostic X-ray and laboratory services.

PAYING FOR THE PROGRAM

Of funds currently raised from the present payroll tax (one percent of wages up to $3,600 per year), about 53 cents for each covered employee per month is used for hospital benefits, $12 cash reimbursement for each day in the hospital up to a maximum of twenty days. The amount now available for hospital benefits obviously would not cover a health plan such as that described above. The following table indicates estimated additional funds that would become available for health benefits, based on an additional one percent payroll tax.

By increasing the Unemployment Compensation Disability tax from one to two percent and raising the taxable wage limit from $3,600 to $6,000, approximately $6.50 per month per worker would become available; a ceiling of $10,000 would yield about $7.50. Examples of group health plans presently available at such prices are (1) California Physicians' Service Health Plan for California State Employees Association members, and (2) Kaiser Foundation Health Plan "BB" coverage. Both these plans provide hospital, surgical and medical services for the employee but not for his dependents, at slightly less than $7 per month.

The estimates assume that about one-sixth of the first one percent tax on the first $3,600, as well as all additional funds raised, would be available for health benefits. Actually, since the cost of benefits now provided exceeds the current income of the UCD program, additional funds will be needed to maintain the present level of benefits. When these are covered, the additional funds from the added one percent would be available for health benefits.

INTEGRATION OF UCD PROGRAM WITH PRESENT HEALTH PLANS

Funds from an expanded Unemployment Compensation Disability Program as described above would adequately cover the cost of a basic health plan for a worker. Funds from collectively bargained and other employer-employee plans already in existence could be used to provide prepayment protection for the workers' dependents, as well as to supplement the basic UCD health plan for the worker himself.

EXPANSION OF COVERAGE BY UCD

Of 5,800,000 people employed in California, about 2,000,000 are not covered under the UCD program and many among these are not protected by any form of prepayment.(31) Some of these are agricultural workers, employees of interstate railroads, public employees, domestic workers and self-employed persons. If the UCD program were expanded to include these groups, except federal government and interstate railroad employees (who are covered by other plans), an additional 1,800,000 workers would be brought into this program.

The Committee recommends that in order to broaden the prepayment of health services as recommended by this Committee, new sources of revenue, both private (individual and organized) and public be found, and that to this end a special objective study be initiated, to be aimed particularly at the problem of financing a minimum of prepaid health service for substantially the entire population, as well as the problem of financing State supported programs other than prepaid health services.

PUBLIC SECTOR OF CARE

Almost $580 million a year from government sources is spent in California for health services, excluding capital outlays. Approximately $125 million of this amount comes from the federal government, mostly for the care of veterans.(32) State tax funds supply $260 million, of which almost one-half is spent for the care of the mentally ill.(33) Approximately $195 million of local government funds spent on health services goes principally to maintain county hospitals.(34)

PEOPLE ELIGIBLE FOR PUBLIC MEDICAL CARE

Since World War I, the greatest amounts spent by the federal government for medical and hospital care have been for veterans. In California, federal hospitals provide about one-fifth of all hospital care for all persons, both public and private.

California, like most states, spends more money on the operation of hospitals for the mentally ill than for any other State-supported health service—about $120 million annually, excluding capital outlays.(33) The State also provides medical and hospital care for crippled children, health services in connection with vocational rehabilitation, and for other types of care for which federal funds are pooled with State, and sometimes local funds. For other types of illness, such as tuberculosis and alcoholism, the State partially subsidizes treatment services operated by local agencies. It has been a growing State responsibility to provide matching funds for health services to recipients of

various categories of public assistance programs—the needy aged, the blind, children and the disabled.

Traditionally, health services to indigent persons have been furnished by California counties. During recent years, county hospitals have assumed increasing responsibility for the health care of the growing number of aged, many of whom have long-term illnesses and limited financial resources. In 1955, for example, county hospitals furnished about one-third of all hospital care (in terms of number of days of care) for Californians over 65.(19)

WAYS OF PROVIDING CARE

Government provides care largely through the direct operation of facilities, which accounts for more than half the money it spends for health care. The Veterans' Administration operates several hospitals in California and the State Department of Mental Hygiene and the counties operate mental and county hospitals respectively.

In recent years, however, government has been purchasing care from hospitals, physicians and other vendors. For example, the Veterans' Administration's "home-town medical care programs" permits veterans eligible for care to select physicians in their own communities. The Medicare program buys similar health services for dependents of armed forces personnel, and California's public assistance medical care program pays for services of physicians and other private vendors, a practice also long followed by the Crippled Children Services.

California also subsidizes certain services which are administered directly by local agencies. The earliest of these were established for tuberculosis programs. The State now pays subsidies to local agencies for mental illness programs (Short-Doyle), rehabilitation of alcoholics, and other health services.

A promising development in the use of government funds is for demonstration health projects. Using funds earmarked for this purpose, health agencies in California have initiated programs designed to improve the quality and enlarge the scope of care for older persons, control chronic diseases and protect workers from occupational hazards.

One such example is the program of the Fairmont Respiratory and Rehabilitation Center in Alameda County, which trained nurses for working with disabled and elderly persons. Three-week courses were given twice a year for three years. Approximately 150 nurses from all parts of California received this intensive training in modern rehabilitation concepts and principles related to reducing disability due to chronic illness.

Another example is the program by the San Mateo County Health Department, which under supervision of a medical team from the San Mateo County Hospital, equipped a private nursing home for physical and occupational therapy to demonstrate what can be accomplished by providing restorative services in nursing homes for bedridden patients.

These projects indicate that many advances can be made in solving community health needs without excessive increase in government expenditures.

The Committee recommends that the State provide funds for demonstration projects designed to develop more economical and effective patterns of health care.

SOURCES OF FUNDS

General taxes raised by local, State and federal governments provide most of the public funds for health services in California. However, the State uses several other methods for raising money for health care. The most important is the Unemployment Compensation Disability Insurance mechanism which taxes wages and salaries (see previous section on the Unemployment Compensation Disability Program). The recently established alcoholic rehabilitation program is financed from alcoholic beverage license fees. Funds used to furnish medical and hospital care for occupational accidents and illnesses are provided through insurance required by law.

QUALITY OF CARE

Like nongovernmental health programs, standards for governmental health services have been receiving much attention recently. Those directly operated by government, as the veterans' hospitals, State mental hospitals and county hospitals, have been improving in line with the general improvement in private institutions. In making funds available to states and local communities, the federal government specifies only a national minimum standard; many states, however, such as California, maintain health services at higher levels.

Health service programs supported by the State vary considerably in specifying standards of quality. For example, the Public Assistance Medical Care Program does not specify any qualifications for the services rendered by medical practitioners. On the other hand, the Crippled Children Services require that participating hospitals meet certain standards and that physicians be specially qualified.

The quality of State health programs could be improved if local governmental agencies were supported only when they met certain standards set by the State. (In the case of the tuberculosis subsidy, this method has worked effectively for many years.) Although the quality of care generally is good, procedures are needed which would enable the State to set up guidelines and standards for State and local health programs, which currently differ widely among various localities.

PREPAYMENT FOR GOVERNMENT EMPLOYEES

About 875,000 workers—about 15 percent of the total labor force in California—are employed by fed-

eral, State and local governments.(31) Until recently, with the exception of some local agencies, government has not provided financial assistance in obtaining prepaid health services to these employees either for themselves or their dependents. As recently as 1953, of 44 counties and 85 cities in California participating in a survey of health and welfare benefits, only 28 percent of the counties and 27 percent of the cities paid part or all of the cost of prepayment plans for their employees.(35) No local agencies with large numbers of employees provided such assistance.

By 1959, for the same group of counties and cities, the proportion paying part or all the cost of employee prepayment plans had increased to 73 percent and 82 percent, respectively. Although the City and County of San Francisco is now paying a part of the cost of prepayment for its employees, other large jurisdictions such as the County of Los Angeles, City of Los Angeles, City of Oakland and Los Angeles City School District are not.

On July 1, 1960, the federal government embarked on a major prepayment program for its employees and their dependents. In California it covered about 190,000 workers and 230,000 dependents, and this is now the largest health plan operating in California.(36) Employees may choose from among several different types of health plans and may select either a high or a low option in each plan. Prepayment charges for the high options range from $17.36 to $22.92 per month for an employee and his dependents; low options range from $11.06 to $16.68.(37) The federal government contributes a maximum of $6.76 a month for each employee.

Employees of the State of California are one of the few large groups of workers still without any prepaid health plan administered or financed at least partly by employers. Including retired employees, University of California and State College faculty and employees, this group totals nearly 135,000 persons.(37) Various groups of these employees have arranged for prepaid health protection with insurance companies and health service organizations under a variety of prepayment plans.

The California Assembly Committee on Civil Service and State Personnel is now considering a proposal to provide prepayment for all State employees, active and retired, to be financed partly by the State.

The Committee recommends the State exert leadership in the field of voluntary prepayment for health care by setting up a program for State employees which follows the prepayment principles set forth in this report.

Analysis of the health needs of State employees should be made by a qualified agency of the State and a plan or several plans be tailored to meet employee needs. After specifications are developed, competitive bids should be invited. The amount and extent of benefits to be provided should be established by the State agency which administers the program. Consideration should be given to establishing two levels of benefits, as was done in the Federal Employees Health Benefits Program.

The high level should include the most comprehensive benefits possible. Particular attention should be given to certain benefits current health plans seldom provide. These are: psychiatric care in and out of hospital; preventive health services, such as physical examinations, immunizations and diagnostic tests not related to specific illnesses; drugs and medicines outside the hospital; refractions; eyeglasses; hearing aids.

The Committee recommends that the State develop specifications for a comprehensive prepaid health program.

As has been noted previously, prepayment organizations have begun to assume responsibility for upgrading prepayment plan standards of quality. Financial incentives and other devices have also been provided to control excess costs. One device for achieving economy in a state program is to restrict the number of plans available to a minimum number consistent with freedom to choose from among basically different types of prepayment plans. The Committee believes that the greatest economy would result from limiting employee choice to one indemnity plan, one contractual service plan (e.g., Blue Cross, Blue Shield) and one or more direct service plans (e.g., Kaiser Foundation Health Plan, Ross-Loos Medical Group) operating in the various geographical areas of the State. The Committee believes that automatic blanketing into a new program of existing plans by a "grandfather clause" is undesirable.

The Committee recommends that a State agency that can provide leadership and technical skills in the health and prepayment fields, and continuously evaluate the cost and quality of medical care provided, be made responsible for the program.

The Committee recommends that retired employees and their dependents be enrolled at the same premium rates and benefit coverages as active employees, and that local public jurisdictions be permitted to enroll their employees in the State health plan.

REFERENCES

(1) *Social Security Bulletin*, U.S. Department of Health, Education and Welfare, October 1959, Table 6.

(2) *Survey of Current Business*, U.S. Department of Commerce, July 1959, Table I-8.

(3) U.S. Department of Commerce, Bureau of Labor Statistics, Consumer Price Index.

(4) U.S. Department of Labor, Bureau of Labor Statistics, "Medical Care: Average Retail Prices in 20 Cities."

(5) *Hospitals*, Vol. 34, No. 15, Part II, August 1, 1960. pp. 366-386.

(6) *Health Statistics*, U.S. National Health Survey, Series B, 1957-1958.

(7) State of California, Department of Public Health, California Health Survey, 1958, (unpublished data).

(8) Kramer, Lucy M., "Drugs and Medicine," *Public Health Reports*, Vol. 73, No. 10, October 1958, p. 931.

(9) Greenfield, Harry J., Anderson, Odin W., *The Medical Care Index*. Health Information Foundation Research Series No. 7, pp. 7-10.

(10) Anderson, Odin W., "Hospital Charges in the United States," *Hospitals*, Vol. 31, No. 10, May 16, 1957, p. 49.

(11) Health Insurance Institute, news release, June 21, 1960.

(12) *Report of the Joint Legislative Committee on Health Insurance Plans*, State of New York, 1959, Legislative Document (1959) No. 35, p. 72.

(13) *Source Book of Health Insurance Data*, Health Insurance Institute, 1959, p. 12.

(14) *Voluntary Health Insurance and the Senior Citizen*, State of New York Insurance Department, 1959, Table 2, p. 6.

(15) Adjudication of Francis R. Smith, Insurance Commissioner of the Commonwealth of Pennsylvania, in the matter of the filing of the Associated Hospital Service of Philadelphia (Blue Cross) made November 14, 1957, p. 3.

(16) Anderson, Odin W., Sheatsley, Paul B., *Comprehensive Medical Insurance*, Health Information Foundation Research Series No. 9, p. 29.

(17) California Department of Industrial Relations, Division of Labor Statistics and Research (unpublished data).

(18) *California's Older People: Their Health Problems*, California Department of Public Health, Table 15, p. 47.

(19) *Health in California*, California Health Survey, 1954-1955. State of California, Department of Public Health, pp. 32-33.

(20) "Health and Welfare Plans in California Union Agreements." Excerpt from *California Industrial Relations Reports*, No. 19, August 1959, p. 2.

(21) Direct correspondence with Health Insurance Association of America, May 24, 1960.

(22) "Standards for Determined Non-conformity of Individual Disability Policies." Title 10, Administrative Code Chapter 5, Sub-chapter 2, Article 1.5, California Department of Insurance, p. 5.

(23) State of California, Insurance Commissioners' Annual Reports, 1955-1958.

(24) Direct correspondence with Blue Cross and California Physicians' Service.

(25) Follman, J. F., Jr., "Regulation of Accident and Sickness Insurance" in McCahan, David, Editor, *Accident and Sickness Insurance*, Philadelphia, University of Pennsylvania, 1954, pp. 226, 240.

(26) *Health and Medical Care in New York City*. Committee for the Special Research Project, Health Insurance Plan of Greater New York, Cambridge, Massachusetts, Howard University Press, 1957, p. 7.

(27) Darsky, B. J., Sinai, N., Axelrod, S. J., *Comprehensive Medical Services Under Voluntary Health Insurance*, Cambridge, Massachusetts, Howard University Press, 1958, pp. 52-54.

(28) Standards of "Michigan Health Service Plan," adopted by Board of Trustees, January 28, 1960.

(29) *Prepayment for Hospital Care in New York State*, School of Public Health and Administrative Medicine, Columbia University, 1960.

(30) Progress Report of the Foundation of Medical Care of San Joaquin County, November 1, 1958, p. 56.

(31) *Newsletter*, Vol. 14, No. 1, California Department of Employment, September, 1960.

(32) Direct correspondence with various federal agencies.

(33) State of California, Budget for fiscal year July 1, 1960-June 30, 1961.

(34) Direct correspondence and reports of various State agencies.

(35) Special Survey of Health and Welfare Benefits in California Local Government Agencies, California Personnel Board, November, 1959.

(36) Telephone conversation, Administrator, 12th Civil Service Region, July 15, 1960.

(37) U.S. Civil Service Commission, Bureau of Retirement and Insurance, Federal Employee Information Booklets.

(38) Correspondence of State Employees Retirement System to Assembly Interim Committee on Civil Service and State Personnel, March 9, 1960.

Chapter 5

HOSPITALS FOR A GROWING CALIFORNIA

The Problem

Huge expenditures for hospital facilities have been necessary in order to keep pace with the health care needs of the great increase in California's population since 1940.

The vigorous action of many sponsors has succeeded in building nearly one-half of the State's 150,000 hospital beds since World War II, at a cost of almost one billion dollars. This has resulted in a ratio of 9.5 beds of all types for every 1,000 people in California.

It is estimated that California's population, now over fifteen and one-half million, will reach over twenty-five million by 1975.(1) If hospital construction is to continue at its present rate, enough to maintain the ratio of 9.5 beds of all types for every 1,000 people, nearly one and one-half billion dollars must be spent for new buildings between now and 1975 and another one-half billion dollars for modernizing existing facilities (Appendix Table 2). Financing this construction represents a staggering public burden, regardless of the source of funds.

Patients frequently are hospitalized because there are no appropriate community facilities which provide a more satisfactory method of treatment. Also, some prepaid insurance plans require that the patient be in the hospital before reimbursement can be obtained. In county hospitals, nursing homes and State mental hospitals, patients are admitted for long periods of hospitalization because there seems to be no other more appropriate place established in which to treat them.

To a large extent hospitals are caught in the sweep of economic forces beyond their control—high labor costs, increased expense of equipment and maintenance, and scarcity of personnel. Lack of organized planning has, in many instances, led to expensive duplication of services and poor distribution of facilities.

Hospital care of high quality can be provided with fewer new beds if certain principles of planning are accepted and activated. The Committee proposes a goal of 7.5 beds per 1,000 population, with the recognition that this can be attained only after several years of strenuous Statewide effort. Planning for proper geographic distribution, type, size and use of facilities must be subject to continuous study and revision in compliance with changing circumstances—advances in medical science, changes in medical practice and economic and social developments.

The Committee believes that with proper planning 7.5 beds can produce the same level of service now being provided by 9.5 beds, and at a savings of more than $650 million in construction costs alone between now and 1975.

To attain this goal, the Committee recommends that:

1. *The State establish a basis through which regions of California can develop long-range programs for coordinated expansion and use of hospitals and related health facilities and services. The State Department of Public Health should be responsible for developing regional plans based on recommendations of Regional Advisory Councils composed of representatives of the public, hospitals and physicians. State funds for administration of the program should be appropriated.*
   (Proposed legislation is appended)

2. *The State make funds available to counties for local programs designed to reduce need for hospital beds through rehabilitation and home care. Existing State programs which encourage prevention, rehabilitation and related health care should be extended.*

3. *The State establish a program to guarantee construction loans by banks and other lending agencies to nonprofit community hospitals to provide an adequate and dependable source of loan funds to supplement voluntary donations, grants of government funds and other sources of capital financing.*
   (Proposed Constitutional Amendment and Legislation are appended under which the program will be financially self-supporting after initial organizational costs are covered by an appropriation.)

ROLE OF HEALTH FACILITIES IN MODERN MEDICAL CARE

Hospitals and other health facilities in California are not components of a highly organized hospital system which functions under central control and direction. Many types of institutions, under various kinds of public and private ownership and control, provide these services. (Appendix Table 3.) These include general hospitals, mental hospitals, chronic disease hospitals, nursing homes, tuberculosis hospitals, rehabilitation centers, public health centers and other specialized facilities, and they are operated by religious and other voluntary nonprofit organizations, private owners, counties, cities, hospital districts and the State and federal governments.

The Committee is conscious of the high standards of health care which have developed in this country through modern medical practice and the evolutionary growth of the voluntary hospital system. In the Committee's judgment, it is desirable to develop methods by which the present voluntary system, in cooperation with governmental agencies, can find solutions to current problems. It is felt that this would be preferable by far to creating a system of hospitals centrally administered and controlled.

Services of hospitals and related medical institutions are now a vital component of modern medical care and have become increasingly complex and costly. As medical science continues to advance, the medical and other health professions will place greater reliance on hospitals and related institutions. This will have great influence on the development of California hospitals for the next several years. The role which community health services are to play in modern medical care and the actions which can be taken to improve their capacity for public service must be identified and clearly expressed.

RESPONSIBILITY FOR MEDICAL AND HEALTH CARE

In making available highly organized, technical, complex and expensive services, the hospital does not practice medicine and does not assume responsibility for medical treatment of patients. These functions are the physicians'. However, hospitals and related institutions do have extensive legal, moral and other responsibilities for the quality of medical care provided in the institution. The medical staff exercises control by authority of the hospital's board of trustees.

As a community medical center, the hospital has responsibility for assuring that patient care can be extended beyond the walls of the hospital into the community through such activities as home care programs.

PUBLIC NATURE OF HOSPITALS AND RELATED HEALTH INSTITUTIONS

Many hospitals had their origin in church activity and private philanthropy. The public character of nonprofit hospitals is recognized by laws which exempt them from income and property taxes. In California, nonprofit hospitals may exercise the right of eminent domain, ordinarily reserved for agencies of government. California's constitution and statutes recognize nonprofit hospitals as "public agencies". The public nature of institutional services also is established through hospital and health facilities operated by county government, the State mental hospital system, hospital districts, cities, the State university and agencies of the federal government.

While hospitals are primarily public service institutions, the Committee found that some confusion exists as to the role of hospitals in modern society because some are operated for profit and others on a community service basis. Failure to resolve this issue clearly underlies some of the difficulties in achieving maximum public benefit from health institutions. If hospitals are to function as community service institutions rather than competitive enterprises, profit must be subordinated to patient welfare.

RESPONSIBILITY OF GOVERNMENT FOR HEALTH CARE

While each person has the responsibility for maintaining his health, he has the right to expect that all health resources will organize their activities and discharge their responsibilities in a manner which will make health service of a high quality readily and effectively available.

In the past 15 years, licensing by the State Departments of Public Health and Mental Hygiene has added to the standards of voluntary organizations. Licensing establishes standards for construction, equipment, safety and sanitation, food services, and professional staffing, including nurses and other professional employees. It does not cover standards of medical practice, except by requiring that medical staffs be organized, and that orders for medical treatment be in writing.

Government has a primary responsibility for furnishing leadership in providing medical and institutional care. Social, economic and political factors play an important part in this relationship.

No overall plan for construction of new hospital and medical facilities would be complete without taking into account governmental as well as voluntary services.

EXTENT OF SERVICES

More than 2,000,000 Californians now spend over 43,000,000 days per year as hospital patients in all types of institutions. This is approximately three days per person per year. (Appendix Table 1.) Older people use approximately twice as much hospital service per capita as younger people.(2) There are many other factors which influence the use of hospital facilities by people throughout the State.

Appendix Table 1 shows the distribution of care in California's general and specialized hospitals. The general hospital provides service for more than 95 percent of all the people who receive hospital care annually, and most admissions to other hospitals are made through them. Since the average stay per admission is short, the general hospital provides only approximately one-third of the total days of patient care furnished by all health facilities. The five percent of patients who are admitted to psychiatric hospitals, long-term care facilities and tuberculosis hospitals, use approximately two-thirds of the total volume of patient service as measured in patient days.

RELATIONSHIP OF GENERAL HOSPITALS WITH OTHER HEALTH CARE FACILITIES

California's general hospitals often are badly located and of inappropriate size to meet community needs effectively. Their relationship with other specialized health care facilities, such as chronic disease hospitals and nursing homes, are inadequately developed to provide continuity of patient care. In addition, community general hospitals have been unable or unwilling to provide specialized services for the care of mental patients and those requiring long-term care.

Traditional sponsorship through religious organizations and other nonprofit groups has failed to develop facilities needed to keep pace with the demands of California's growing population. In some regions, the gap has been filled by direct government action in building county and district hospitals. In other regions, there has been substantial building by proprietary owners. At present, 51.8 percent of the general hospital beds in the State, other than State and federal hospitals, are in nonprofit hospitals; 16.9 percent in profit hospitals; 21.9 percent in county hospitals; and 7.7 percent in district and city hospitals. (Appendix Table 3.)

LONG-TERM CARE AND MENTAL HOSPITAL

California has more patients in mental hospitals than in general hospitals on any given day. Admissions to all mental hospitals, including those to State mental institutions, account for only 2.6 percent of total admissions, but these receive 47.9 percent of the total patient days of care in California. State hospitals admit 1.1 percent of the total admissions and provide 38.9 percent of the total patient days of care. (Appendix Table 1.) There are very few beds in private mental hospitals, and most of these provide primarily custodial care. Few general hospitals have organized psychiatric departments.

For many patients, particularly the senile and retarded, visiting nursing care can replace hospitalization. It is estimated that 17 percent of patients now in State hospitals are senile. If early diagnosis and treatment programs and community psychiatric services were adequate, probably 10 to 30 percent of all patients in mental hospitals could live at home.

County hospitals and independent nursing homes with limited staffs and services meet as best they can the need of the aged and other patients who require long-term care, but these facilities are often inadequate and isolated from community medical resources.

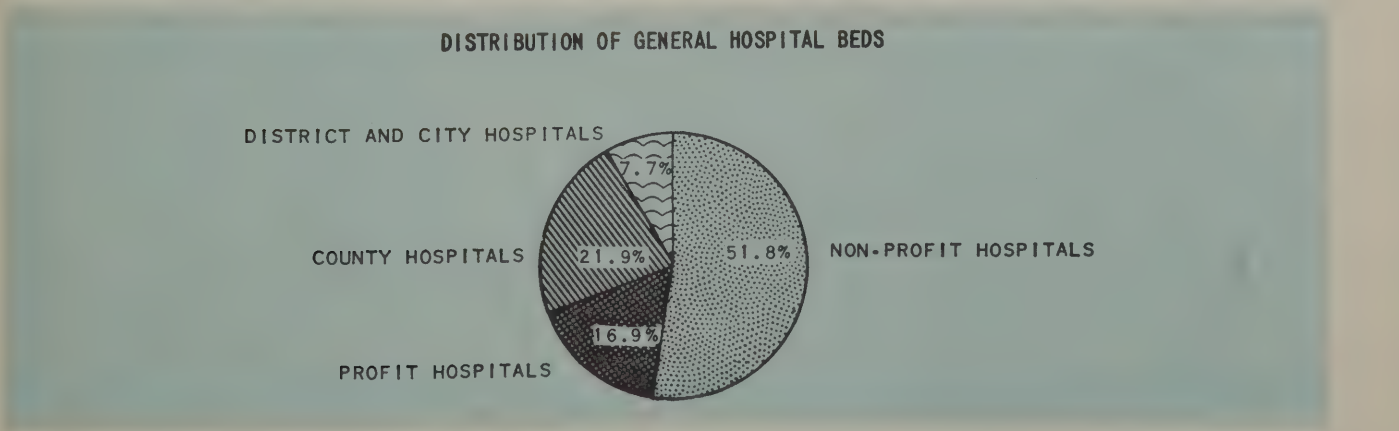
FACTORS WHICH LIMIT THE ABILITY OF HEALTH FACILITIES TO PROVIDE PUBLIC SERVICE

Independent action by various public and private groups has produced hundreds of hospitals in California in a relatively short time. The total number of hospital beds has increased at approximately the same rate of growth as the State's population. However, these beds at times do not meet community needs effectively because of type, size and location of the individual hospitals.

Voluntary and public agencies have not provided clear objectives for the guidance of individual hospitals, nor have they succeeded in securing compliance by all hospitals with the limited community planning objectives which have been established.

In metropolitan Los Angeles from 1950-1959, ninety new general hospitals were built. All but 7 were smaller than 150 beds, and all but 17 had less than 100 beds. Projecting this to 1975 would result in 160 additional general hospitals in Los Angeles, with only 14 having 150 or more beds.(3)

This problem is exaggerated in Los Angeles, but exists in varying degrees throughout the State. Lack



DISTRIBUTION OF GENERAL HOSPITAL BEDS

of coordinated planning has resulted in duplication and inappropriate use of expensive services and facilities, gaps in essential services, competition, and overbuilding in some areas and underbuilding in others.

It is the Committee's conclusion that California hospitals have developed in the past ten years in a haphazard manner which is not in the best public interest. Projecting California's 1950-1960 building patterns to 1975 would, in the Committee's opinion, be disastrous.

NEED FOR BETTER PLANNING

California has made a beginning in planning through current activity of hospitals, professional groups, community organizations and agencies of State government, including the State Department of Public Health, which administers the Hospital Survey and Construction Program. But there is an urgent need for planning California's hospital expansion to provide for a population increase of ten million within the next 15 years. This planning, to be effective, must reflect both Statewide and local viewpoints in such a way that voluntary and governmental resources can be mobilized most productively.

DEVELOPMENT AND APPLICATION OF REGIONAL PLANS IN CALIFORNIA

Real pressure exists to develop improvements in hospital planning, coordinate hospital use and develop better methods for collecting and analyzing information on hospital use. The issue in California is how best to mobilize the interest and force of the public, health professions, hospitals, other voluntary agencies and government, in a manner which will be most effective and productive.

The legislative proposal recommended by the Committee makes the State Department of Public Health responsible for devising long-range regional plans based on recommendations of regional advisory councils. These councils should be composed half of physicians and hospital representatives, and half of consumers.

Regional plans should make estimates of future needs for each type of facility in relation to population growth, plan facilities of appropriate type, size and location, provide coordination of functions of individual hospitals, and establish a basis on which to gain adherence of individual hospitals to overall community planning objectives. Proposals for construction or expansion of hospital facilities not in accord with an approved regional plan would not be processed by the State Department of Public Health or Mental Hygiene until reviewed by the regional advisory council. Should the proposal prove to be in substantial conflict with the regional plan, the council would be empowered to order public hearings.

The general hospital, as the key institution in the hospital system, should enlarge its scope to provide comprehensive community health services, including long-term care, psychiatric services, rehabilitation, organized home care programs, laboratory and other diagnostic services to assist the community's practicing physicians. Regional plans should encourage rehabilitation programs to restore the aged, the handicapped and the chronically ill to the maximum degree of self-sufficiency.

Regional planning should also encourage progressive patient care in hospitals—the grouping of patients according to their degree of illness. Fullest possible use of organized home care programs should be advocated, particularly by county hospitals and in metropolitan regions. Careful consideration should be given to ways of avoiding duplication of specialized and costly services. Programs in appropriate institutions for educating doctors, nurses and other health personnel should be developed.

Regional councils should assume leadership in encouraging intensive treatment programs for patients with mental illness in community general hospitals and specialized local mental hospitals. These programs should include:

. . . diagnostic and treatment centers affiliated with local, general or psychiatric hospitals to screen patients for outpatient care, short-term care in general hospitals or commitment to long-term care institutions.

. . . psychiatric units for short-term care in community general hospitals. General hospitals in larger communities should establish organized services of a minimum size of 20-30 beds. In smaller communities, all general hospitals should be encouraged to establish some beds to accommodate psychiatric patients.

. . . postdischarge services. These facilities should serve mental patients who no longer require treatment in mental hospitals, but who are not ready to return to their homes and resume their place in the community.

. . . sheltered workshops, foster home care, nursing home care, day hospitals and night hospitals—to give support and guidance to patients without requiring them to be 24-hour residents in a psychiatric hospital.

Regional plans should include development of public health center construction and programs. Individual hospitals and medical facilities should devise time schedules for necessary expansion and modernization within the framework established by the regional plan.

The Committee recommends that the State establish a basis through which regions of California can develop long-range programs for coordinated expansion and use of hospitals and related health facilities and services. The State De-

partment of Public Health should be responsible for developing regional plans based on recommendations of Regional Advisory Councils composed of representatives of the public, hospitals and physicians.

(Proposed legislation is appended.)

NUMBER OF HOSPITAL BEDS— COMMITTEE'S GOALS

There is now a ratio of 9.5 hospital beds per 1,000 people in California. The Committee proposes a goal of 7.5 beds, with recognition that this can be attained only after several years of strenuous Statewide effort. An important factor will be development of community health services designed to reduce the need for new hospital beds.

The Committee's proposal is at variance with the gauge used by the Hospital Survey and Construction Program which calls for 4.5 general hospital beds per 1,000 people, five mental beds, and three to five long-term care beds.

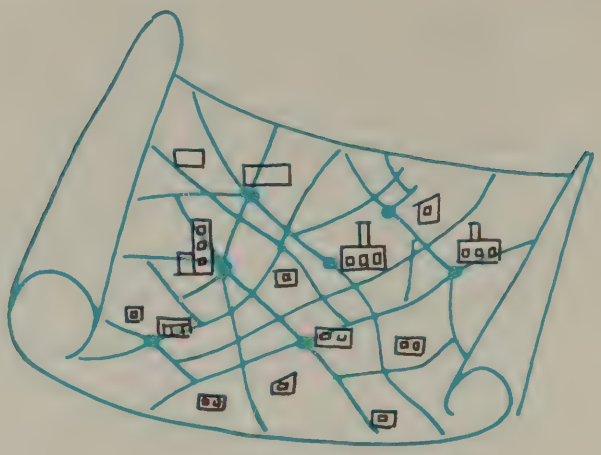
Existing bed ratios, goals proposed by the Public Health Service and the Committee's goals are compared in the table below.

The attainment of the Committee's purposes depends on planning for proper geographic distribution, type, size and use of facilities. Its goals must be subjected to continuous study and revised in compliance with advances in medical science, changes in medical practice and economic and social developments.

The Statewide goal of 7.5 beds does not mean that each community in the State has identical needs. In establishing future goals, it will be imperative for regional councils to be flexible and responsive to special conditions in each region.

1. General Hospitals

Average use by each person in California is approximately one patient day of general hospital service per year. Excluding federal hospitals, more than two-thirds of this service is in nongovernmental facilities, and about one-third is in State, county and district hospitals. At present,



47,890 beds, or 3.2 beds per 1,000 population, provide this service. In addition, 4,885 beds or 0.3 beds per 1,000 population are under construction. (Appendix Table 3.)(3)

General hospitals cannot have every bed occupied every day of the year because patient load rises and falls on a seasonal basis, and hospitals must always have available capacity to meet emergencies. Small hospitals which have less flexibility in their operations tend to have lower average occupancy than larger hospitals. Hospitals of 200 or more beds in California have occupancy rates of approximately 75 percent while those with less than 25 beds have an average occupancy of less than 57 percent.(3)

It is reasonable to assume that more appropriate size and location would permit an average annual bed occupancy of 75 percent or higher. As Appendix Table 6 indicates, the present volume of service per capita in general hospitals can be provided with three beds per 1,000 population, if an average annual occupancy of 75 percent of all general hospitals can be maintained. At the present time in many parts of California, more hospital beds exist than are needed.

Establishing a planning base for general hospitals of three beds per 1,000 people in 1975

CATEGORY	BEDS PER 1,000 POPULATION			
	United States		California	
	Exist 1958	Goal for 1970 Proposed by PHS	March 15, 1960 Exist and Under Construction	Goal for 1975 Proposed by Committee
Total	7.52	9.52	9.5	7.5
General	3.43	3.93	3.5	3.0
Mental	2.60	3.10	3.9	3.0
Long-Term	1.49	2.49	2.1	1.5

means that California will need 75,900 beds, or 23,125 more than now exist or are under construction. The building rate will vary from year to year, averaging 1,541 beds per year. Ordinarily, a hospital is under construction for approximately two years, so the number of beds under construction at any time will be about 3,100. These beds are included in the Committee's planning estimate of three beds for 1,000 population. Construction under way at any one time probably will not exceed 0.2 beds per 1,000 population, leaving approximately 2.8 beds per 1,000 population for actual use.

The development of community programs for home care, clinics and rehabilitation should reduce the demands on general hospitals for inpatient care from the present ratio of 3.2 beds per 1,000 population to the proposed 2.8 beds.

2. Mental Beds

Currently, California has 3.9 psychiatric beds for every 1,000 people, with less than one-fifth providing active treatment programs.(3,5) A reasonable estimate of need for 1975 is three psychiatric beds for every 1,000 people. This is based on the expectation that present progressive programs which depart from the old traditions and practices in the treatment of mental illness will be accelerated.

There should be substantial realignment of the responsibilities of State government, local government, public and private agencies and individuals. More care should be provided in communities, and extension of prepayment to cover psychiatric care would permit patients to assume larger financial responsibility for their own care.

Of particular urgency is the necessity to stimulate active treatment programs in State mental hospitals, general and specialized hospitals, and noninstitutionalized psychiatric services in local communities.

Cheap custodial care which continues indefinitely should be replaced by intensive treatment programs which will shorten periods of hospitalization and be more humane, effective and economical.

To provide the recommended ratio of three beds per 1,000 population in 1975 will require 75,900 beds, or 17,724 more than now exist. (Appendix Table 2.) The Committee proposes that the proportion of total beds in which active treatment is provided be increased to at least one-third of the total number of beds in comparison with the present 18.1 percent. It further proposes that half of these beds for active treatment be provided in State and county hospitals and the other half in general and specialized hospitals in local communities.

Realization of this goal will mean development of approximately 3,300 additional long-term care beds and approximately 14,400 beds for active treatment between now and 1975.

Following is the basis on which these estimates are made:

3. Long-term Facilities

California now has 31,493 beds in chronic disease hospitals and nursing homes providing long-term institutional care. To provide 1.5 beds per 1,000 population by 1975 will require 37,950 beds, or 6,457 more than now exist (Appendix Table 2). If public and private community general hospitals establish long-term care units for the aged and chronically ill, and develop affiliations with nursing homes and similar institutions, a reduction in long-term care beds can be achieved gradually. Without clearly established, comprehensive and coordinated community programs for treating chronic illness, the only prospect is a self-defeating program of building additional beds for custodial care. Enlightened programs in several public and private hospitals

CATEGORY	EXISTING 1960	PROPOSED 1975
	3.9 Beds Per 1,000	3 Beds Per 1,000
Total Psychiatric Beds	58,176	75,900
Total Long-Term Custodial Treatment	47,274	50,600
State	40,268	
County	-	50,600
Community general hospitals	-	
Community private hospitals	7,006	
Total Short-Term Treatment	10,902	25,300
State	8,040	12,650
County	930	
Community general hospitals	448	12,650
Community private institutions	1,484	

have demonstrated that patients with chronic illness frequently can be treated more effectively outside than inside institutions.

4. Tuberculosis Hospitals.

There are 5,184 beds in tuberculosis hospitals. Use of specialized institutions for this disease is decreasing rapidly. (Appendix Table 3.) The present number of beds appears adequate to take care of the current population and substantial population increase between now and 1975. This is in sharp contrast to 1947, when it was estimated that the State needed 9,598 tuberculosis beds.(3)

The declining need for hospital beds for tuberculosis presents a possible source of beds for other patients requiring long-term care.

DEVELOPING COMMUNITY HEALTH SERVICES

Extensive community health services to keep people out of the hospital and speed their return home have not been developed. In the Committee's judgment, there is need for State action to mobilize community support for organized programs which stimulate health maintenance, preventive and therapeutic services which can reduce the need for institutional care.

Counties appear to be the appropriate agencies to establish local programs for this purpose. Counties are responsible for operating county hospitals throughout the State and for most of the State's organized public health activities.

In addition to the goals set for general hospitals, specialized hospitals and nursing homes in each region, goals can also be established for organized county-sponsored programs. The purpose of these would be to reduce need for institutional care by promoting rehabilitation and self-sufficiency among many patients who must now seek care in general hospitals, mental institutions, specialized hospitals and nursing homes.

The Committee recommends that the State make funds available to counties for local programs designed to reduce need for hospital beds through rehabilitation and home care. Existing State programs which encourage prevention, rehabilitation and related health care should be extended.

COST OF SERVICE IN HOSPITALS AND RELATED HEALTH FACILITIES

A conservative estimate of the annual cost of hospital care to Californians is three-fourths of a billion dollars. Of this amount, 58.4 percent is expended on nongovernment, and 41.6 percent on government hospitals. This includes cost of operating all public and private hospitals, including federal, nonmilitary hospitals. Appendix Table 4 covers distribution of this cost.

SOUND PROGRESS IS BEING MADE

An outstanding characteristic of general hospital service in California is that the average patient stay is relatively short as compared with that in other parts of the country. As a result, total costs for the treatment of the average patient in a California general hospital compare favorably with those in many other states, despite the higher cost per patient day in California.

NUMBER AND TYPES

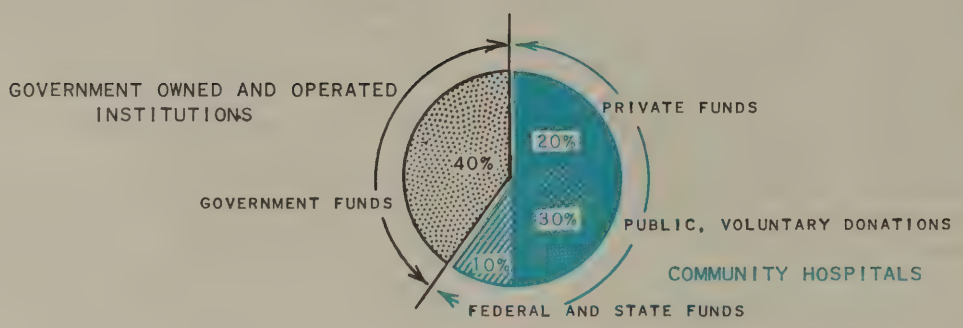
California has more than 1,500 hospitals and health facilities of various types which contain approximately 150,000 beds. There are 487 general hospitals, while more than 1,000 are specialized institutions for treat-

COMPARISON PATIENT COSTS IN SHORT-TERM GENERAL HOSPITALS AMONG SELECTED STATES, U.S., 1959

STATE	AVERAGE LENGTH OF STAY	SHORT-TERM GENERAL HOSPITALS	
		Cost per Patient Day	Cost Per Case
California	7.5	$38.20	$286.50
New York	9.9	32.58	322.54
Pennsylvania	9.3	25.86	240.50
Illinois	8.5	31.97	271.75
Michigan	8.0	34.38	275.04
Florida	7.1	30.65	217.62
Missouri	8.7	26.84	233.51

Source: Hospitals, Journal of the American Hospital Association, Guide Issue, Part II, August 1, 1960, pp. 372-385.

SOURCE OF CONSTRUCTION FUNDS



ment of tuberculosis, mental disorders and long-term care. Eleven are Federal Government institutions. Appendix Table 3 provides detailed information on the number and type of these institutions and beds.

In the past 10 years, 64,813 new hospital beds have been built in California, involving an investment of almost a billion dollars. Appendix Table 5 contains detailed information on hospital construction since 1950. Private sources provided approximately one-half of the funds to finance this construction, and government the rest.

FINANCING COMMUNITY HOSPITALS

An important cause of haphazard hospital construction in California is the lack of dependable sources for construction funds for community hospitals. The California Hospital Survey and Construction Program has made grants of federal and State funds to community hospitals since 1946, but these grants have covered only 10 percent of the cost of all hospital construction in the State. Community fund drives for construction are an inadequate source of funds. Banks and other financial organizations often are unable to make funds available to community nonprofit hospitals.

Since World War II, approximately $300,000,000 has been spent by voluntary nonprofit hospital organizations for hospital construction. Thirteen of the 15 nonprofit community hospitals now under construction in the California Hospital Construction Program had to borrow from 40 to 100 percent of the local funds required. These 15 projects borrowed nearly $9 million while fund drives provided only $6 million.

In addition to voluntary contributions, nonprofit hospitals need a dependable source of loan funds from banks and other lending agencies to permit them to finance their construction in an orderly manner. The Committee believes it is proper for community hospitals to use income from patient care toward retiring debt incurred in building. To provide a reliable source of funds, it is proposed that a constitutional amendment be presented to the people which would authorize the State to provide construction and modernization loan guarantees for nonprofit community hospitals. The proposed program would authorize the State, through the Department of Public Health, to study existing facilities and establish a schedule of priorities for construction and modernization of hospital facilities for which insurance guarantee could be provided. Loans would be limited to 75 percent of estimated construction cost, and would be repaid within 25 years.

Application for insurance would be made through a lending institution, and would include evidence of financial feasibility and demonstration of ability to repay the loan. Loan guarantees would be made only for construction which complies with regional plans. Availability of loan funds for community hospitals would discourage construction not in the interest of the community.

The Committee recommends that the State establish a program to guarantee construction loans by banks and other lending agencies to nonprofit community hospitals to provide an adequate and dependable source of loan funds to supplement voluntary donations, grants of government funds and other sources of capital financing.

(Proposed constitutional amendment and legislation are appended under which the program will be financially self-supporting after initial organizational costs are covered by an appropriation.)

DISSENTING COMMENTS

"I disagree with the position taken in this chapter for the following reasons:

1. This chapter deals in an unsatisfactory way with the most important issue raised by the Governor's Committee: the need to develop effective regional planning of California's health services. It limits its efforts to a program to control the mushrooming of substandard proprietary hospitals. Important as this problem is, it is only one of many hospital problems, and it can be dealt with more directly than proposed by regulations requiring all hospitals to conform to reasonable standards of care. Organization of medical care and facilities go hand in hand. Yet no attempt is made to relate the hospital section to the recommendations on regional planning contained in the chapter on 'Organization and Distribution of Services.'

2. The best of California's hospitals are superior, but the overall pattern is one of uneven quality. Upgrading hospital care is certainly as important as reducing the cost of hospital construction. Yet this chapter is written as if what goes on inside hospitals is irrelevant. Although it states that hospitals are 'primarily public service institutions' and that 'government has a primary responsibility to furnish leadership,' it then proceeds to evade the principal issue: the necessity for government regulation to safeguard the public. Ample precedents for such regulations exist in controls government exercises over public utilities, banking and finance, corporations, labor unions and other agencies whose activities affect the public welfare. At the very least, all California hospitals should be required to meet the standards of the Joint Commission on Accreditation of Hospitals, minimal as these are. About half of the State's institutions are not accredited. This is a serious situation.

3. The major emphasis of this chapter is on saving money rather than on creating an efficient and economical hospital system that meets the needs of our people. We can save money on schools by not building them. Similarly, we can save money on hospital construction by not building the hospitals we need. Great emphasis has been placed in this chapter on reducing the ratio of hospital beds to population by 1975 from 9.5 beds to 7.5 beds per 1,000 population. Nowhere does it justify these arbitarary bed ratios. Indeed, it recommends reducing bed ratios in every type of hospital facility without a clear analysis of why this is desirable or how it can be accomplished. In addition, the chapter calls shorter hospital stays by patients in California 'sound progress.' No attempt is made to say why this is good. The average hospital stay by patients in Mississippi (5.8 days) is even shorter than in California. Does this make hospital organization in Mississippi preferable?

4. There are a multitude of omissions. No program is suggested to deal with problems such as high costs, utilization, rate increases, and other such problems. No attempt is made to find solutions for the shocking problem of the State's nursing homes.

These are only a few of my objections to this chapter. In general it discusses only a fragment of an extremely serious problem and even in the area that it covers, the supporting data does not substantiate its recommendations."

Harry Polland

"This chapter deals with some of the most immediate problems in the field of medical care. Tremendous progress has been made under the leadship of the California (State Health Department's) Bureau of Hospitals in dealing with these problems in such a way as to keep up with the population explosion now taking place in California. This very immediacy has tended to distract attention from longer range policy. I summarize my specific differences with this chapter of the report as follows:

1. *I concur with the analysis made by Mr. Harry Polland.*
2. *More attention should be given to specific ways of reducing the high cost of hospital care in California.*
3. *I do not think that capitalization charges and loan costs should be billed to patients in the form of high fees for hospital services; such practice makes the sick people and those least able to pay bear the capital costs of hospitals.*
4. *The accounting practices whereby hospitals make 'income-producing' charges on certain items should be reviewed and eliminated.*
5. *Dr. Russel Lee's suggestion for dividing hospitals into less expensive 'going in' and 'coming out' areas, in addition to the 'in' portions of the hospital, should be given immediate consideration for future hospital activities."*

Stephen I. Zetterberg

RESPONSE

"Conclusions and recommendations in this chapter received the active consideration and full approval of the Committee. Advances in medical science are constantly changing the services which hospitals provide. The chapter is factual and proposes specific action by legislation to improve these services.

The proposal for regional planning will enable hospitals to expand in a more orderly manner and to improve their capability to serve the public.

The goals for 1975 are attainable, based on present medical practice and hospital experience. Standards of medical practice in hospitals are discussed in the chapter on diagnosis and treatment."

J. E. Smits

REFERENCES

(1) State of California, Department of Finance, Budget Division, *Preliminary Estimates of California Civilian Population by Age and Sex, 1950-1975.*

(2) *Health in California*, State of California Department of Public Health, 1958.

(3) State of California, Department of Public Health, Bureau of Hospitals records.

(4) *Principles for Planning the Future Hospital System*, U.S. Department of Health, Education, and Welfare, Public Health Service Publication No. 721.

(5) Joint Commission on Accrediation of Hospitals, December 31, 1959.

Chapter 6

HEALTH MANPOWER FOR CALIFORNIA

The Problem

California faces a shortage of health personnel to meet the needs of a rapidly increasing population. Maintenance of health and treatment of disease require a growing number of various highly trained specialists. In addition to the medical specialists themselves, of which the profession now recognizes more than two dozen, these services depend on dentists, nurses, research workers, psychologists, social workers, technicians, therapists and many others.

Shortage of personnel in any one field of medicine affects all fields; a physician without a nurse or technician is more limited as to the numbers of patients he can see. Sufficient psychiatric staff to provide effective patient care in the community would make it possible to treat many mentally ill patients without hospitalizing them. Economic and humanitarian benefits can be derived from rehabilitation, but there are too few trained people to do the work needed in this field. More medical schools are needed to educate more doctors, but vacancies on medical school faculties attest to the need for training more teachers.

Manpower shortages are complicated by the changing functions of the workers in the field of health. In the past decade, doctors who would formerly have become private practitioners, have turned to research, hospital service, preventive medicine and teaching. Modern nursing demands a diversity and breadth of skilled personnel, ranging from nurses' aides, who can be trained quickly and inexpensively, to the teachers and administrators who must be educated at the graduate level. New technology and developments call for new scientific disciplines and personnel.

California's needs for the services of health personnel will increase markedly by 1975 because of population growth. Rising educational and income levels and broader prepayment coverage will also accelerate the demand. Because of shortages of personnel as well as improved professional opportunities elsewhere in the country, a relative drop is anticipated in the number of out-of-state physicians, dentists, professional nurses and other health workers who will move to California in the years ahead.

If adequate numbers of qualified health personnel for California are to be trained by 1975, existing public and private schools must be expanded rapidly and new ones established. Teachers must be obtained or trained, a larger number of qualified students must be recruited, more efficient use must be made of the scarce professional skills, and training programs must be adapted continually to changing health care patterns.

The Committee recommends that:

1. *California proceed at once to expand medical educational capacity in private and public institutions, with the goal of 1,400 first-year places by 1971. As first steps in this program, the State should:*

   a. *Provide funds for 200 additional first-year places in public medical schools;*

   b. *Help meet the great educational cost borne by medical schools by providing students at all California medical schools with funds to pay additional charges that would more nearly cover the schools' actual costs of medical education, but develop such a grant-in-aid program only if increased enrollment in the private schools is assured;*[1]

   c. *Conduct a study of medical education costs at each California medical school using the Association of American Medical Colleges cost-finding procedures and determine the amount of grant-in-aid on the basis of such cost studies;*

   d. *Provide special scholarships and loans to selected financially needy students.*

2. *California proceed at once to expand dental educational capacity in private and public institutions, with the goal of 785 first-year places by 1971. As first steps in this program the State should:*

   a. *Provide funds for 100 additional first-year places in public dental schools;*

b. Help meet the educational costs borne by dental schools by providing students at all California dental schools with funds to pay additional charges that would more nearly cover the schools' actual costs of dental education, but develop such a grant-in-aid program only if increased enrollment in the private schools is assured;

c. Conduct a study of dental education costs at each California dental school and determine the amount of grant-in-aid on the basis of such cost studies;

d. Provide special scholarships and loans to selected financially needy students.

3. California proceed at once to expand professional nursing educational capacity in public and private institutions, with the goal of 1,600 baccalaureate degree graduates and 3,400 junior college and hospital program graduates by 1975. As first steps in this program, the State should:

a. Provide funds and encourage the raising of funds necessary for doubling the training capacity of nursing schools in California, to produce 1,200 additional graduates per year;

b. Encourage expansion of junior college nursing programs by providing special funds to enable the schools to maintain appropriate faculty-student ratios;

c. Establish a program of scholarships for nurses preparing for teaching and other leadership positions. The number of scholarships provided for this purpose should be 100 per year.

4. California proceed at once to expand educational capacity for social workers, clinical psychologists, public health workers, occupational and physical therapists and other allied health professions, and proceed to gather information to determine precise needs for such personnel.

5. The schools for health personnel periodically re-examine their educational programs to assure that education be of high quality and that curricula are adapted to changing patterns of health care.

6. A Health Manpower Liaison Committee composed of representatives of interested public and private agencies be established to advise periodically the State Department of Public Health on health manpower problems and requirements. The Committee should encourage and develop programs for determining how the different professional health skills can be put to best use, and for recruiting larger numbers of qualified persons into the various health professions. (This Committee and its functions should be incorporated in the Advisory Council on Licensing and Certification proposed in the chapter on Diagnosis and Treatment in this report.)

DISSENTING COMMENT

[1] *"I believe that many of the organizational and financial problems of medical care in California would be solved, at least in part, by increasing the number of physicians available in California. However, I do not approve recommendation 1.b. in its present form. In addition to administrative and technical difficulties, this recommendation runs counter to other Statewide educational programs. In other programs the State is assuming the responsibility of providing college facilities to take care of the population shift to California and the population growth of California; in this recommendation, it appears that an effort is made to shift this assumption of responsibility to private organizations. I feel the State should meet the needs for medical schools squarely and set its sights high, and not commit itself to substitute patch-work procedures which in first instance may seem to save money but would in the long run prove costly. My same comments, of course, would apply on recommendation 2.b."*

Stephen I. Zetterberg

CALIFORNIA'S NEEDS FOR HEALTH PERSONNEL

The Committee believes that California's needs for health personnel in 1975 can best be appraised by analyzing the current situation. Because the many factors affecting need are hard to measure, suggested numbers are rough estimates based on current California ratios of health workers to population.

Thus a minimum goal for California would be to maintain the present ratio of about 175 doctors of medicine and osteopathy and 61 dentists for every 100,000 persons. (1,2,3) The Committee recommends these goals even though it is unlikely that the State can establish enough new medical and dental schools soon enough to prevent ratios from falling.

Current demands for professional nurses in California exceed the number available. The ratio of nurses to population has declined over the past few years, from 353 for every 100,000 in 1950 to 269 in 1957. During this period the national ratios increased. The demand for nursing services will increase in the next 15 years. The present California ratio is too low and should be increased to 300 by 1975, the minimum standard recommended by the National League for Nursing.(4)

Translating goals such as these into numbers of new health workers means that by 1975, California would need to add about 2,300 new physicians, 800 new dentists and 5,900 new nurses each year. These estimates take into account the predicted population increase and anticipated loses due to retirement, death and other causes, and are considerably more than current annual increases in these professions.

California relies heavily on out-of-state sources for health personnel. Seven-eighths of newly licensed physicians, almost half of new dentists, and more than three-quarters of new nurses currently added to the professions annually are graduates of schools outside of California or the United States.(5,6,7,8) California's professional opportunities, expanding economy and pleasant climate will doubtless continue to attract professional people from other areas, but it is unlikely that the number migrating to the State each year will rise above present levels.

Other states also face growing shortages of health personnel; many are therefore trying to attract health personnel from other areas and to retain those they train by special measures such as loan programs. Often young physicians who now come to California for specialized graduate training remain to practice. Increased opportunity for such training elsewhere will contribute to the expected relative decline of physicians drawn from out-of-state over the next 15 years.

Because other states have similar problems in meeting increased training costs, state legislatures generally impose residence restrictions for admission to public medical schools. Relative to its population, California has fewer training places than many other states. The proportion of Californians accepted for training in out-of-state schools will decrease, thus further limiting the opportunity for California students to study medicine. California's urgent need for all types of trained health personnel makes it imperative to devise new methods for financing educational institutions and for recruiting students if health personnel needs are to be met in the coming years.

In the Committee's opinion, the professions concerned should periodically re-examine licensing regulations to eliminate arbitrary restrictions for out-of-state persons. The Committee believes that for some of the professions, licensing requirements and procedures could be developed that would encourage and enable greater in-migration without lowering professional standards. To the applicant, examination procedures sometimes appear confusing, time-consuming and arbitrary.

In 1959, the number of doctors licensed from out-of-state was equal to approximately nine percent of the State's total number of physicians.(5,6) The same year, the number of out-of-state dentists licensed was about two and a half percent of dentists in California.(7)

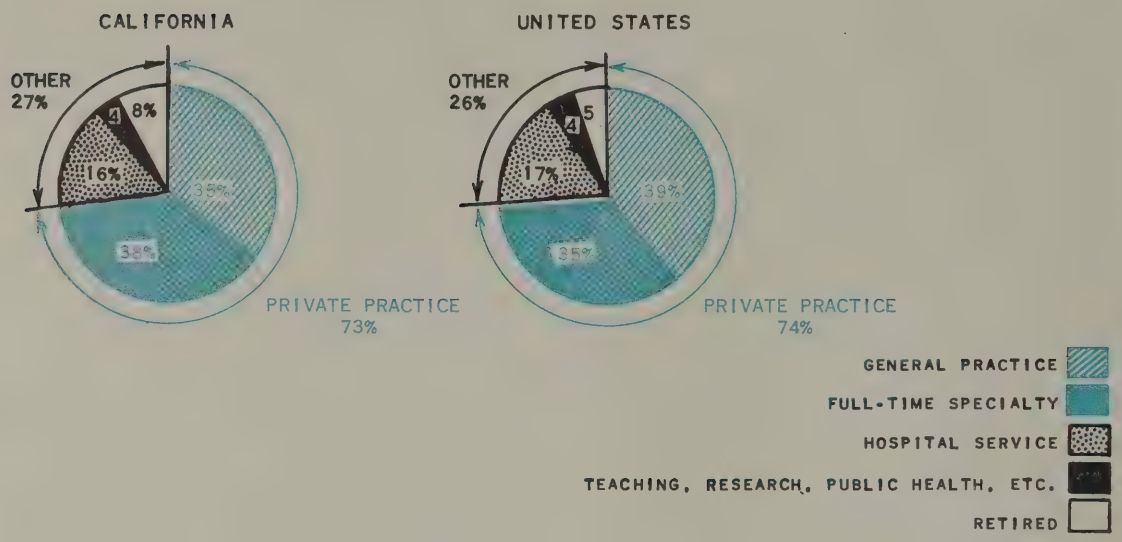
NEED FOR PHYSICIANS

In 1959, California's ratio of 175 physicians [1] (doctors of medicine and osteopathy) for every 100,000 people was higher than the national average of 141.(1, 2) This ratio probably will decline by 1975, even if immediate steps are taken to increase the number of physicians educated in California medical schools.

Nineteen thousand physicians, or about three-quarters of the State's doctors, were in private practice in 1959. The proportion of full-time specialists—over half of all private practitioners—is higher in California than in the United States as a whole.(1,2) As elsewhere, most active physicians not in private practice

[1] Includes retired and other nonpracticing physicians.

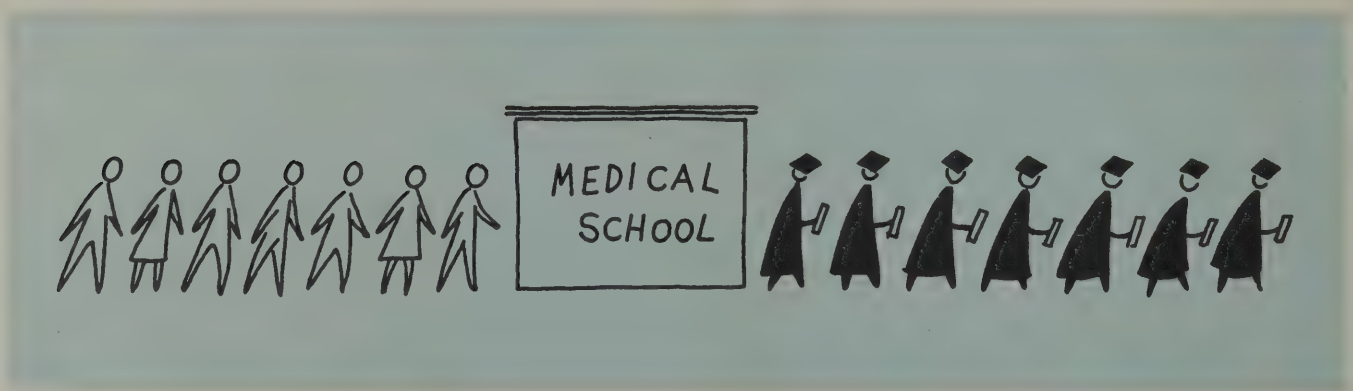
TYPE OF PRACTICING PHYSICIANS (M.D. and D.O.)
California, United States, 1959



are in hospital service, either as interns or residents, or in other fulltime hospital posts. California has a higher ratio of retired or nonpracticing physicians than the nation generally.(1,2)

California's five medical schools and the College of Osteopathic Physicians and Surgeons together enroll about 500 first-year students each year.(9,10) With adequate funds, first-year enrollment at the two existing State medical schools could be expanded from the present total of 175 to about 250 (125 at each school). Establishment of the proposed University of California School of Medicine at San Diego would provide for 100 more first-year places. The remaining places could be provided only by further expansion of existing schools or by establishing new ones.

Allowing for some loss of California graduates to other states, and a small number of drop-outs during training, California will need about 1,400 first-year medical school places by 1971 in order to maintain the present population ratio in 1975.



PROJECTED (1975) NEED FOR PHYSICIANS IN CALIFORNIA[1]

PERSONNEL NEED	PHYSICIANS (M.D. AND D.O.)
Total number required in 1975 to maintain present physician-population ratio (175 per 100,000)	44,300
Total annual additions needed in 1975 (if present ratio is maintained between now and 1975)	2,300
Number of annual additions expected from out-of-State schools	1,300
Number of annual additions required from California schools	1,000
Total California graduates needed, allowing for out-migration	1,340
Total first-year places needed in 1971, allowing for attrition during training	1,400
Present number of first-year places	500
Proposed expansion of University of California enrollment (3 schools)	175
Additional first-year places needed	725

[1] Based on present physician-population ratio.

HIGH COSTS OF MEDICAL EDUCATION

To expand the capacity of California medical schools will require a large amount of money. Medical school construction and operating costs are extremely high. In California, moreover, they vary widely between schools, although enrollments are of comparable size.[1] A detailed cost analysis is needed to determine the percentage of each school's budget devoted to each major function of medical education: training of medical students, interns and residents, postgraduate students, paramedical students, research, patient services, and community services.

The Association of American Medical Colleges has recently recommended that medical schools adopt a uniform cost accounting system.(11) If this procedure is put into effect, cost comparisons of the five California schools can be made to determine actual costs for each category of student. Since the budget figures now available cover all training activities of the medical schools in addition to research and other services, it is not possible to compute precisely the average yearly cost of training one medical student.

The Committee urges the adoption of the A.A.M.C. cost-finding procedures at the two University of California medical schools with cost information to be developed and reported to the legislature. Private schools also should be invited to submit cost data, determined according to the same procedures. This information would be important for the following reasons:

1. To determine why the expenditures of the public schools are considerably higher than those of the private schools.
2. To determine the dollar amount of the grants-in-aid recommended for aiding the schools to meet operating costs.
3. To determine how much money is necessary for expanding existing medical schools and for a new public medical school. Until cost infor-

[1] A questionnaire developed by the Association of American Medical Colleges (A.A.M.C.) was used to determine the 1958-1959 operating costs of the five California schools. The questionnaire provides a good general measure of the levels of expenditures at each of the five institutions.

CALIFORNIA MEDICAL SCHOOL EXPENDITURES FOR REGULAR TEACHING, RESEARCH AND SERVICE PROGRAMS[1], ENROLLMENT AND FACULTY, 1958-1959

SCHOOL	TOTAL EXPENDITURES[1]	ENROLLMENT			FULL-TIME FACULTY EQUIVALENT
		Undergraduate Medical Students	Ph.D. and Master's Candidates	Interns and Residents	
University of California, San Francisco	$4,829,540	338	41	281	164
University of California, Los Angeles[2]	4,336,016	208	74	159	170
College of Medical Evangelists	2,058,664	371	24	458	120
University of Southern California	1,437,844	260	49	344	107
Stanford University	1,950,254	237	23	226	116

1 Excludes grant-sponsored and other outside programs, and teaching, hospital and clinic costs.

2 Cost may be somewhat inflated because U.C.L.A. is a new campus. According to university spokesmen 16 undergraduate medical students are being added to each class without increasing present operating costs.

Note: Because accounting procedures of the reporting institutions differ, figures reported are not exactly comparable.

Source: Journal A.M.A., Annual Education Number, November 14, 1959. Direct correspondence with the medical schools.

mation can be analyzed in relation to specific school programs and the educational purposes of new and existing schools clarified, it must be assumed that the capital and operating costs of a new public medical school would parallel those of present institutions.

The A.A.M.C. cost-finding procedure relates to operating costs only. It would also be helpful in supplying the Legislature with information relating to costs of construction, completed and proposed.

Financial support required for medical education is so great and the need for greater capacity so critical, that extreme care must be exercised to use available funds in the most productive manner.

Inadequate operating funds are the principal obstacle to expanding California's private medical schools. To meet operating costs, the private schools now must raise $4 or more in gifts for every $1 of tuition. Spokesmen for the schools believe that if the State were to assist the schools in meeting operating costs, capital funds for expansion could be raised from community resources.

Recognizing the heavy cost to the State of establishing more than one or two new public medical schools in the next ten years, and in view of the educational potential of the private schools, the Committee favors expansion of private school enrollment through State aid. Indications are that a grant-in-aid program of $3,000 to $4,000 per year per undergraduate medical student would be required to achieve expansion of the private schools. This amount would provide the equivalent of one new medical school in California at no capital cost to the State, and more rapidly than a new facility could be developed. The Committee also believes that the proposed financial aid would stimulate the establishment of new private medical schools —again, at no capital cost to the State.

State aid should not be limited to California residents because this would place pressure on the schools to give preference to these students. There is evidence that students tend to remain to practice in the State in which they are trained.(1) Also, residence restrictions tend to shrink the pool of qualified applicants. Most medical educators feel that this is undesirable.

Studies of better methods for providing high quality education at lower cost are now under way at various medical schools. More such studies should be undertaken. Possibilities should be explored for developing two-year programs of basic science for medical students, especially in graduate schools now offering similar courses for Ph.D. candidates. However, such programs must be coordinated with the programs of four-year medical schools. California's medical schools could quite readily absorb additional third and fourth year students in their present clinical teaching facilities.

Among deterrents to young people who might otherwise choose a medical career are the length and cost of the education. One-fifth of a sample of California's public medical school graduates in 1959, reported average total expenses of $12,500 or more for four years of education. A little more than one-half of the sampled students at the private schools had similar average expenses. Over one-half of both samples were in debt, some as much as $5,000.(12) New doctors must complete one year of internship before they can begin practice. If they wish to specialize, they must undertake an additional three to five years of residency training.

In recent years, medicine has lost ground in recruiting students to other branches of science and technology. New opportunities in other specialized fields involve shorter training time and lead to equivalent economic rewards, prestige and professional status. The greater availability of scholarship and loan funds in these fields places the medical schools at a disadvantage in competing for students.

Thus, California's medical schools—all of which attract many applicants—experience difficulty in finding an adequate number of qualified students. Larger numbers of able young people must be encouraged to study medicine. Sufficient scholarships and loans, from State and private sources, should be provided to enable medicine to compete with other occupations in attracting students.

The Committee recommends that California proceed at once to expand medical educational capacity in private and public institutions, with the goal of 1,400 first year places by 1971. As first steps in this program, the State should:

a. Provide funds for 200 additional first-year places in public medical schools;

b. Help meet the great educational cost borne by medical schools by providing students at all California medical schools with funds to pay additional charges that would more nearly cover the schools' actual cost of medical education, but develop such a grant-in-aid program only if increased enrollment in the private schools is assured;

c. Conduct a study of medical education costs at each California medical school using the Association of American Medical Colleges' cost-finding procedures and determine the amount of grant-in-aid on the basis of such cost studies;

d. Provide special scholarships and loans to selected financially needy students.

NEED FOR DENTISTS

The supply of dentists in California in 1959 was about 9,200—or 61 for every 100,000 persons.(3) This ratio is higher than the national average of 56 for every 100,000 population, but has declined by about seven and one-half percent since 1953, and according to estimates, will show a further substantial drop by 1975. (11, 3, 7)

Since 1954 California has added between 450 to 475 dentists a year, of whom somewhat under half are from out-of-state schools. Recently, the average number of out-of-state graduates licensed annually has declined, falling from 257 in 1954-1955, to 215 in 1958-1959. In the same period, the average number of California graduates licensed increased from 217 to 251 a year.(7)

Because no provision exists in California for reciprocity in the licensing of dentists already licensed for practice in other states, each new dentist must pass the examination given by the California Board of Dental Examiners. Applicants who are graduates of California dental schools usually can pass the examination; in the 1958 and 1959 fiscal years only one out of a total of 502 California trained applicants failed. Among out-of-state graduates, the failure rate is considerably higher, averaging 54 percent in the past two years.(7) This is partly due to the fact that a sizable percentage of these applicants had been out of school for some time, and also had not been "trained for the test" in the way California students are.

To maintain the present ratio of dentists to population in 1975, the Committee estimates it would require increasing each year the number of California graduates licensed and out-of-state dentists licensed by the California Board from the 1959 level of 466 until it reaches about 815 in 1975.

Assuming that the number of out-of-state dentists licensed continues to be about 215, the remaining 600 new California licentiates needed in 1975 would have to come from California schools. If allowance is made for about 15 percent of the California school graduates moving to other states, the total number of graduates needed would be about 705. With attrition of students at the present rate of about 10 percent, the total number of first-year places needed by 1971 to provide 700 graduates in 1975 would be about 785.

At present there are about 295 first-year places in California's four dental schools (University of California at San Francisco, College of Medical Evangelists, College of Physicians and Surgeons, and University of Southern California). Of the 490 additional first-year places required by 1971, about 150 will result from planned expansion of existing schools and the establishment of a new school at the University of California at Los Angeles. The remaining 340 places would have to come from further expansion of existing schools and other new schools.

As with the medical schools, necessary expansion of dental school capacity in California will require large amounts of money. Although additional student places will probably be provided in the State dental schools,

PROJECTED NEED FOR DENTISTS IN CALIFORNIA, BASED ON MAINTAINING THE PRESENT RATIOS OF DENTISTS TO PEOPLE IN 1975

PERSONNEL NEEDED	DENTISTS
Total number required in 1975 to maintain present dentist-population ratio (61 per 100,000)	15,400
Total annual additions needed in 1975	815
Number annual additions expected from out-of-state schools	215
Number annual additions required from California schools	600
Total California graduates needed, allowing for out-migration	705
Total first-year places needed in 1971, allowing for attrition during training	785
Present number of first-year places	295
Planned expansion	150
Additional first-year places needed	340

Note: Based on present dentist-population ratios.

private schools also should be encouraged to expand. State grant-in-aid to dental students, similar to those recommended for medical students, would greatly aid private schools to meet educational cost.

Measures to help in recruiting qualified dental students must accompany the expansion of educational capacity. Already some California schools are finding it difficult to fill their first-year classes. Dentistry faces many of the same problems as medicine in competing with other professions for qualified students.

In 1956-1957 the estimated average cost of dental education in the United States was $11,000 for single students and $15,000 for married students. Almost three-fifths of the nation's dental students were substantially in debt at the time of graduation.(13) State and private scholarships along with low cost loans are needed to attract potential dental students.

The Committee recommends that California proceed at once to expand dental educational capacity in private and public institutions, with the goal of 785 first-year places by 1971. As first steps in this program, the State should:

a. Provide funds for 100 additional first-year places in public dental schools;

b. Help meet the educational costs borne by dental schools by providing students at all California dental schools with funds to pay additional charges that would more nearly cover the schools' actual costs of dental education, but develop such a grant-in-aid program only if increased enrollment in the private schools is assured;

c. Conduct a study of dental education costs at each California dental school and determine the amount of grant-in-aid on the basis of such cost studies;

d. Provide special scholarships and loans to selected financially needy students.

NEED FOR NURSES

In 1957, California had a ratio of 269 registered, professional nurses in active practice for every 100,000 population as compared with 261 for every 100,000 population for the nation as a whole.(4) The North Atlantic states show the highest rates of any area with 336 nurses for 100,000 population. In the West, three states (Colorado, Montana and Wyoming) have 300 or more nurses for every 100,000.(4,14)

Although registered professional nurses live in all areas of California, they tend to concentrate in metropolitan centers. Many nurses have left the field—only about 60 percent in the State are in active practice. (15,4)

Of the 54 nursing schools in California in 1959, 25 were hospital schools, 15 were located in junior colleges and similar institutions, and 14 were in degree-granting colleges and universities, 10 of which offer only baccalaureate programs for registered nurses, and three of which offer a master's program as well. One school initiated a post-master's program in 1959.(8)

There are too few nurses properly prepared to teach in basic and postgraduate schools and to fill administrative or supervisory posts. Currently, 58 percent of instructors in California schools of nursing do not have the recommended master's degree.(4) Lack of people qualified to serve as directors has delayed the development of new junior college nursing programs. Qualified personnel are also needed for leadership positions in hospitals and in public health.

California's needs for nurses will be met primarily by its nursing schools and by nurses from other states. A systematic recruitment campaign might induce some of the 40 percent of inactive licensed nurses to return to practice, but the potentials of this source are limited.

To achieve the National League for Nursing's recommended minimum ratio of 300 practicing nurses for every 100,000 population in California during the period from 1960 to 1975 would require the addition of a steadily increasing number of new practicing nurses each year, beginning with 4,000 in 1960 and reaching 5,900 in 1975. The number of new licentiates needed, allowing for the prevailing proportion of inactive nurses, would then be about 9,500 for that year. The Committee estimates that if the number of nurses drawn from out-of-state sources continues at the present level of about 4,400 new licentiates annually, the number required from California schools in 1975 would be about 5,100, more than four times the present number of approximately 1,200 graduates per year. (16)

During the past two decades, basic nursing education has been moving steadily from an apprentice type of training program to an academic professional program. Especially since 1953, this shifting emphasis has placed more responsibility for nursing education on tax-supported educational institutions in California; some private and public hospitals have given up their training programs.(4)

The nursing profession needs to study the relationship between nursing practice and preparation. In order to provide an adequate supply of nurses for teaching, administration, supervisory and public health positions, one-third of all graduates in 1975 (about 1,600) would have to be prepared in baccalaureate programs. Two-thirds (about 3,400) would have to be

prepared in hospital and junior college programs, primarily to provide skilled nursing care at the staff nurse level. This would require a seven-fold increase in baccalaureate program graduates and three and one-half times the present number of hospital and junior college graduates.(8)

Recruitment of students for basic nursing programs has improved in the period from 1958 to 1960 because junior college nursing programs are now located in numerous communities and new recruitment sources are being tapped.

In order to increase enrollment of nurse students in the existing junior college programs, some school districts may need special financial assistance from the State. The general teacher-student ratio which serves as a basis for State aid to junior colleges cannot be applied to the junior college nursing programs because one teacher cannot effectively supervise more than 12 nursing students. The nursing education program is therefore more expensive than other junior college programs since it calls for more faculty members per student than do other college majors.

The costs of education, together with the generally low salaries, deter nurses from obtaining the advanced education necessary to qualify them for teaching and supervisory positions. The financial burden of education is especially great for graduates of hospital programs (the bulk of present nurses) who must work toward a bachelor's degree before continuing with graduate training. A program of State scholarships for advanced nursing education would help greatly to recruit a larger number of nurses for such programs. One hundred scholarships a year are recommended for this purpose.

The Committee recommends that California proceed at once to expand professional nursing educational capacity in public and private institutions, with the goal of 1,600 baccalaureate degree graduates and 3,400 junior college and hospital program graduates by 1975. As first steps in this program, the State should:

a. *Provide funds and encourage the raising of funds necessary for doubling the training capacity of nursing schools in California, to produce 1,200 additional graduates per year;*
b. *Encourage expansion of junior college nursing programs by providing special funds to enable the schools to maintain appropriate faculty-student ratios;*
c. *Establish a program of scholarships for nurses preparing for teaching and other leadership positions. The number of scholarships provided for this purpose should be 100 per year.*

NEED FOR ALLIED PERSONNEL

In recent years the demand for social workers, clinical psychologists and other allied health workers has been so great that these professions have been forced to employ many persons who have not had adequate professional training. Information on the numbers employed in many of these fields, and how they are trained and deployed is fragmentary and scanty. Detailed studies are needed of the supply and distribution of these workers. Personnel shortages in many of these areas are critical.

Growing demand for allied health personnel and the increase in the number of specialties, require increased public and professional attention. The problems of recruiting dietitians and laboratory technicians, among others, need to be explored. The proper functions of groups such as dental hygienists, health educators, social workers, optometrists, and vocational nurses, in relation to closely allied occupational groups, should be studied.

State colleges and junior colleges, with limited participation by public and private universities and colleges, should be able to carry most of the load in training allied health personnel. The recent increases in the number of junior college nursing schools has demonstrated the potentialities of those schools for the training of certain types of health personnel. The amount of State support needed to expand educational facilities should be determined by analysis of the cost of additional facilities, the sources of funds available, and the desirability of using particular sources of funds for particular types of training.

The Committee recommends that California proceed at once to expand educational capacity for social workers, clinical psychologists, public health workers, occupational and physical therapists and other allied health professions, and proceed to gather information to determine precise needs for such personnel.

RECRUITMENT

Since successful recruitment of personnel is essential to any plan for meeting California's needs, various factors that affect choice of careers in the health field must be identified. There is no shortage of able young people in California. The problem, rather, is to foster interest in the health professions, provide basic preparation for later specialization, and remove artificial barriers to professional education.

Many factors are involved in motivating students to enter health occupations: general ability, family

background, example of neighbors or friends, encouragement of teachers, and prestige and monetary reward, among many others. A better picture of careers in the health professions needs to be drawn for high school students. The successful recruiting done by various business and industrial groups in the high schools attests to the advisability of making available information about health careers to students. When school counselors and teachers have been equipped with good printed materials and specific knowledge of available training facilities and employment opportunities, they have been effective in interesting properly qualified students. They have also proved effective in leading students into health careers when they have established contact for them with professionals in the community willing to discuss their work with young people.

The California League for Nursing, in cooperation with some ten related voluntary associations and government bodies, studies recruitment problems and promotes Statewide programs to attract people to nursing. Local recruiting is carried on by individual hospitals and colleges and by local nursing organizations and service clubs. To alleviate severe shortages of nurses in State agencies, the State Personnel Board in 1960 employed two nurse recruiters to publicize career opportunities for nurses in State service.

USE OF PERSONNEL

In recent years the health professions have made many improvements which have led to more effective use of personnel. Shortages of trained personnel have been met by supplementing skilled manpower with less highly trained personnel under appropriate guidance or supervision. The result has often been a reduction in cost accompanied by improved quality of care.

> "Use of auxiliary personnel should not be based on the idea that delegation of function is done only to save the time of some mythical paragon who could do every job magnificently if he were not busy doing something else important. Positive emphasis should be placed on the need for many people with a variety of aptitudes, skills, and backgrounds to do the many different tasks that contribute to comprehensive health service."(17)

Some of the professions have expressed concern that differentiation of function may in some cases detract from the unique contribution made by a particular group of health personnel. For instance, the professional nurse has a major responsibility for personal and intimate care of the patient. Yet, with the increase in specialized nursing activities, personal attention to the patient may be lost in a technical and impersonal assembly line type of care. Similarly, increased specialization of physicians should not take place at the cost of a meaningful personal relationship between the patient and at least one "family physician".

Educational programs for health personnel have not always prepared the particular professional workers to take maximum advantage of allied skills in performing their jobs. Earlier this year the University of Southern California dental school received a grant from the U.S. Public Health Service to inaugurate a pilot program in which senior dental students spend a certain portion of their clinical time working with a trained chairside assistant. Such training in work with allied personnel should become standard procedure in all schools for health personnel.

The Committee feels that continuing investigation of further possibilities for improved use of varying health skills is required. Developing and installing new techniques involves extensive cooperation within and among the various professions. Only by supplying these supports can the necessary care be provided during a period when the ratio of physicians and dentists to patients will be declining.

NEED FOR MODIFIED CURRICULA

Although a detailed review of curricula in schools for the health professions has been beyond the scope of this study, the Committee sees some evidence of a tendency for teaching programs to lag behind changes in patterns of health care. The growth of specialties within each profession and among allied groups requires increased attention to curriculum evaluation, to assure a proper balance between their common education and specialized training. Other trends that should be consistently reflected in training include the growing importance of services to the chronically ill, the development of home care and other out-of-hospital medical services, increased needs for rehabilitation activities, and other scientific, economic and social changes which affect the character and organization of health services. Some schools have led in recognizing that curricula should be modified. The Committee encourages intensified efforts to align fully the training of health personnel with the realities of modern health practice.

The Committee recommends that the schools for health personnel periodically re-examine their educational programs to assure that education be of high quality and that curricula are adapted to changing patterns of health care.

NEED FOR HEALTH-MANPOWER LIAISON

In its review of health manpower problems, the Committee has encountered a number of areas which require further study before recommendations can be made. Many aspects of California's needs and requirements could not be explored in detail with the time and resources available. More exhaustive investigation is urgent in the case of most of the allied health professions.

California at present has no central mechanism for considering health manpower problems on a continuing and coordinated basis. How many students are interested in health careers but do not pursue them? How well coordinated are the training programs of the various health professions—many of which increasingly work together in a team relationship? How can comprehensive manpower resource data be collected and analyzed in order to anticipate emerging needs for each group of health personnel? Is full use being made of skills and abilities now available? The need to answer these and other related questions makes it imperative that the State establish a central staff to give continuing attention to health personnel matters, advised by a broadly representative Health Manpower Liaison Committee.

There is precedent for such a staff and advisory committee in the hospital planning activities of the State Department of Public Health, where the Bureau of Hospital staff is joined with the Advisory Hospital Council. The proposed Health Manpower Liaison Committee would include representatives from the University of California and from the State departments which have an interest in health personnel, representatives of the health professions, representatives of the public, and one or more local government officials.

Among the responsibilities of the Committee and the health personnel study staff would be:

1. The achieving and maintenance of an adequate supply of personnel in the health professions.
2. The maintenance of continuous inventories of numbers and distributions of each professional group and the forecasting of manpower supply and needs.
3. The determining of needs in terms of type, size and location of educational facilities.
4. The fostering of improved practices in making use of personnel, and more effective relationships between members of the various health professions.
5. The attracting of qualified professional persons from out-of-state to health careers in California.
6. The conducting of research and fostering of demonstration programs.
7. The promoting and coordinating of recruitment programs and recruitment activities of the various professional groups.

The Committee recommends that a Health Manpower Liaison Committee, composed of representatives of interested public and private agencies, be established to advise periodically the State Department of Public Health on manpower problems and requirements. The Committee should encourage and develop programs for determining how the different professional health skills can be put to best use, and for recruiting larger numbers of qualified persons into the various health professions. (This Committee and its functions should be incorporated in the Advisory Council on Licensing and Certification proposed in the chapter on Diagnosis and Treatment in this report.)

DISSENTING COMMENT

"There have been some practical but important developments in the use of hospitals in connection with medical education. Although these uses may be familiar to many, I think they should be set out in this report. They are as follows:

a. Increased use of community hospitals for 'teaching' and internship relationships with institutions of medical education.

b. Provision in community hospitals that an arbitrary portion of hospital beds, both charity and noncharity, should be used for 'teaching' purposes.

c. The setting up of mechanisms within community hospitals for interns from medical institutions to have increasing day to day contact with doctors on the staff of hospitals as a method of continuing education to staff doctors.

d. Use of interns increasingly in emergency room services in community hospitals in order to expand the availability of such emergency services, and to relieve staff doctors from servicing these emergency units on 'call' basis.

e. Provision for 'foundations' to be used in connection with, but separate from, hospitals in order to accept and use private financial donations to support unusual educational opportunities for local physicians, and in order to finance unusual cooperative educational ventures between medical schools and local community hospitals.

f. As a corollary to the development of prepaid medical programs, the foregoing and other techniques should be developed so that medical schools may be freed from their dependence on 'charity' and 'public assistance' patients and have access to training in procedures and techniques in the community hospitals that may become connected with State medical schools."

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REFERENCES

(1) American Medical Association (unpublished data).
(2) American Osteopathic Association, "Statistical Studies of the Osteopathic Profession", December 31, 1959.
(3) Direct Correspondence with Victor A. Hill, Executive Secretary, Board of Dental Examiners, State of California.
(4) Western Interstate Commission for Higher Education, *Nurses for the West*, 1959.
(5) Journal of the American Medical Association, State Board Number, May 28, 1960, Vol. 173, No. 4, pp. 381-383.
(6) State of California, Board of Osteopathic Examiners, Annual Reports.
(7) State of California, Board of Dental Examiners, Biannual Reports.
(8) State of California, Board of Nurse Examiners, Annual Reports.
(9) Journal of the American Medical Association, Annual Education Numbers.
(10) Journal of the American Osteopathic Association, Annual Education Numbers.
(11) Association of American Medical Colleges, *Program Cost Finding Procedures Manuel*, 1960.
(12) Association of American Medical Colleges, Questionnaire Survey.
(13) *Physicians for a Growing America*, Public Health Service Publication No. 709 Appendix A.
(14) U.S. Department of Health Education and Welfare: *Nursing Resources*, Public Health Service Publication No. 551, p. 2 and Chart 2.
(15) *Registered Nurses in California*, Pocan Mailing List, March, 1960.
(16) California League of Nursing, *Developments of California Programs in Nursing*, 1959.
(17) Caughey, John L., "Auxiliary Personnel in Medical Practice", *American Journal of Public Health*, Vol. 48, August 1958, p. 1052.

THE SPECTRUM OF HEALTH SERVICES

Health services may be viewed as consisting of several components—prevention of illness, diagnosis and treatment of disease, and rehabilitation. Actually these components are somewhat artificial segments of what is really a continuous spectrum of care designed to minimize disease, disability and premature death. Prevention, diagnosis and treatment, and rehabilitation overlap and intertwine to a considerable extent; they shade into one another and together they comprise the essential unity of comprehensive health service. This may readily be seen by examining the approach to several specific disease situations.

Malaria, which only a few decades ago affected hundreds of persons in the State every year, has been practically eradicated. The rare case identified nowadays is usually someone arriving already infected from a foreign country where the disease is endemic. This successful prevention—in fact, eradication—of malaria resulted from environmental measures, namely control of the mosquito known to be the carrier of the disease.

Another means of preventing the occurrence of disease is to immunize people individually, and thus build their resistance to specific diseases. Virtual elimination of smallpox through vaccination illustrates what can be accomplished in this way. Occasional small outbreaks of the disease emphasize the need for universal vaccination and periodic revaccination. Poliomyelitis is now ready to be conquered through application of the principle of immunization. But the problem of long-term treatment and rehabilitation of those disabled before the vaccine was available—and more tragically, after its availability—remains.

Rheumatic fever, until recently, was one of the major causes of chronic heart disease. Now that prompt and effective treatment of streptococcal infections of the throat with antibiotics has become common medical practice, the disease is rapidly declining. This is an instance in which early and adequate treatment of a condition (streptococcal infection) will prevent the occurrence of an important complication (heart disease).

Detection of syphilis early in its course and modern drug treatment will prevent general paresis. The latter mental disease, which is due to syphilitic infection of the brain, and which formerly occasioned many admissions to mental hospitals, has become a rarity through control of syphilis. Early casefinding, followed by diagnosis and treatment of syphilis has thus not only reduced the frequency of infectious syphilis, but also has prevented the occurrence of a once common and serious aftermath.

Experience with early detection of diabetes presents somewhat of a parallel to the experience with syphilis. Half a century ago, diabetes led to serious complications and to death, particularly in young people, because treatment in those days was not effective. The discovery of insulin and other means of modern treatment has permitted diabetics to lead almost normal lives, provided the disease is found early. A simple blood test permits detection of the disease even in persons who do not have symptoms of it. Over 100,000 Californians, conservatively estimated, now have the disease but do not know it. They may suffer a variety of complications and shortening of life, which could be avoided by more widespread application of available knowledge.

Stroke, paralysis of a part of the body due to disease of the blood vessels of the brain, is now a common cause of long-term disability. It is the most frequent diagnosis among the thousands of persons in nursing homes in the State. However, much of the disability from this condition could be prevented if patients with stroke received appropriate treatment immediately after onset of the condition, and rehabilitation. Thousands of persons are complete or partial invalids because of failure to provide intensive rehabilitation services to persons with stroke. Some improvement is taking place, but

much remains to be done if rehabilitation of stroke patients is to achieve its full potential for preventing long-term, essentially permanent, disability.

Thus, the terms prevention, diagnosis and treatment, and rehabilitation only grossly differentiate the major segments of the spectrum of comprehensive health services. Their essential unity is the important concept. For purposes of analysis and greater understanding, each component will be discussed further.

Chapter 7

PREVENTION OF ILLNESS

The Problem

Modern disease prevention has moved far beyond the limits of checking the communicable diseases. The paths to its goal are now multiple:

Through *environmental control* (such as control of the bacterial and chemical qualities of water, to prevent typhoid fever and dental caries);

Through *immunization* (against such illnesses as diphtheria, whooping cough and poliomyelitis);

Through early *detection* (of such chronic conditions as cancer of the cervix by the Papanicolaou test, and glaucoma by eyeball tension measurement);

And through *research* (on such problems as coronary heart disease and lung cancer).

The medical and scientific accomplishments of the last few decades have changed the pattern of illness; as a result, the prime centers of medical concern, including preventive medicine, have shifted. While it is still necessary to maintain vigilance over what were formerly the dread diseases, an important task now is to develop means for preventing the "modern epidemics" such as lung cancer and coronary heart disease, which already account for one-fourth of all deaths among adult males in California.(1)

Once it was the menace of water pollution which spurred cities to spend tens of millions of dollars for health protection; today medical and research findings lead them to spend comparable amounts on investigating and curbing the sources of air pollution. And once the emphasis was necessarily on methods for cure of manifest ailment, but now modern medicine is pressing for the systematic application of available techniques for early detection of disease before symptoms or damage occur.

In a world which sees few boundaries to achievement, disease prevention faces new frontiers—both in research and communication. It must foster diligent search for those circumstances of modern life which give rise to our fatal diseases (such as the work which has identified cigarette smoking as a factor in lung cancer), and it must inform the public of discoveries and their significance.

The Committee recommends that:

1. *The State strengthen and broaden its environmental health services to cope with the hazards arising from the rapidly changing chemical and physical properties of our environment, including research into the effects upon health of new pollutants in the environment.*
2. *Local health departments intensify their efforts in behalf of immunization programs against poliomyelitis and other diseases, to reach those segments of the population still relatively unprotected.*
3. *Health agencies, business, industry and professional groups implement programs of multiple screening under medical supervision and with medical interpretation to detect important chronic diseases early.*
4. *Physicians in private practice and governmental and nongovernmental agencies which provide medical services strengthen their efforts in the health education of patients and their families.*
5. *The State bring together research specialists in education, behavioral science and health education to outline areas of needed research in health education methods and to suggest means by which such studies might be stimulated.*
6. *Professional groups, health departments, schools, private agencies and civic organizations concerned about public health make an all-out effort to secure adoption by their communities of practices, such as fluoridation, which have been scientifically proved of value to health.*
7. *Appropriate agencies and groups undertake further research on mental illness, including personality disorders and antisocial behavior, and preschool mental health checkups.*

ENVIRONMENTAL HEALTH SERVICES

Learning to protect himself against disease through control of his environment has been one of man's great achievements. Civilization was menaced by such plagues as cholera and typhoid fever before the dangers of polluted water were exposed and met, and we are now faced with the necessity for a large-scale attack on new environmental health problems.

Application of our rapidly developing chemical technology exposes people to many new and possibly dangerous substances, such as hydrocarbons and heavy metals discharged from automobile exhausts into the air, insecticides used to protect food crops but left on the food as a residue, and even possibly the mineral content of water.

HOUSING

A fundamental requisite to health is adequate housing, not only sufficient living space and protection against the elements and insects, but also proper illumination, ventilation and temperature. Although refrigeration and indoor toilets are accepted necessities, not all California residences have them. Beyond such fundamentals, we have come to expect that today's house should provide safety and privacy for its occupants.

Until recently, improvement in housing could be effected by enforcement of certain minimum require-

ments in building and housing codes. Now urban renewal and suburban development require extensive planning. Better control of land and subdivision development, along with city planning, are necessary if land for industrial, residential and recreational use is to be developed in proper community balance and in the interest of health.

THE WORKPLACE

Next to his home, the workplace probably constitutes the most important part of man's physical and social environment. Improvements in the conditions of work, such as sanitation, and advances in safety design and practices to reduce the rate of occupational accidents, have accompanied industrial progress. Many effective preventive measures are well known to the medical profession and to industrial hygienists, but for the further prevention of occupational diseases and accidents, such measures must first be accepted by workers and employers.

Changes in industrial technology today expose workers to new hazards, especially chemical ones. For example, berylliosis emerged as a disease only after the substance beryllium came into common use a couple of decades ago in the production of a new type of lighting fixture. Animal testing of beryllium disclosed no adverse effect, and it was some years before beryllium was finally recognized as the cause of a chronic and sometimes fatal lung disease in man.

Each year many California farm workers become ill, some fatally, because of exposure to new insecticides; diseases of the skin remain a common problem in industry; certain industrial practices contribute to lung cancer; and industrial use of the radioactive materials creates numerous problems.

FOOD

Although processing and preserving of food have improved greatly, the hazards have not been eliminated. Continuing failure to provide sufficient toilet facilities in California fields where crops are being harvested means that contamination can occur in food

production. Not many years ago, several cases of typhoid fever in the State resulted from consumption of unpasteurized cheese. Efforts to control insects have led to the use of powerful chemical sprays. The extent to which tiny amounts of such chemical residues on food are a danger to health has yet to be determined. Cancer, for example, may develop after many years of exposure to minute amounts of certain chemicals. During 1960, an epidemic of hepatoma (a cancer-like disease of the liver) occurred among hatchery-raised trout in California and other western states, apparently because of a substance introduced into their food. Although the exact mechanism is still undetermined, the episode emphasizes the danger of environmental changes.

WATER

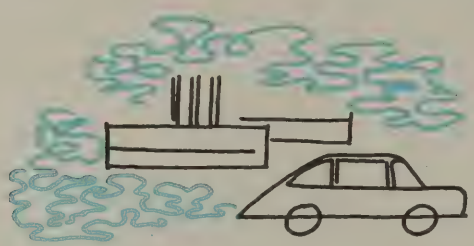
California's growth raises the problem of the availability of water, as well as its sanitary quality. Popula-

tion is now expanding in areas where water has a high mineral content—total solids in excess of 2,000 parts per million. Generally, water becomes unpalatable and can also cause unpleasant physiological effects at about 1,500 parts of total solids per million.[1] (2) Certain ions, such as sodium, nitrate and chlorine, have limits of safety likely to be exceeded near this range of total solids concentration. Beyond these limits, total solids

may become toxic or contribute to dehydration. This problem will be of even greater importance when methods of converting salt water come into use.

AIR

Clean air is a matter of growing concern to public health agencies, not only because of the immediate



eye irritation from smog, but also because unclean air may have long-term effects, such as cancer. Beginning efforts are being made to protect man from harmful air pollution by regulation of waste emissions and by partial purification of air supply to buildings.

Attention to air quality will unquestionably increase in the coming decades. The tasks will be to control air pollution from auto exhaust and other metropolitan sources, make studies of the optimum design for the metropolitan environment, and develop and apply means to control air within buildings.

RADIATION

During recent years, the hazards of man-made radiation, such as leukemia, have become matters of public concern. Besides contamination from nuclear explosions, the danger in the medical uses of X-ray is of major concern. While the X-ray is an important instrument in the diagnosis and treatment of disease, its use can be harmful and should never be undertaken without medical supervision.

The State now checks radioactivity in air, food, water and medical sources of radiation. Data gathered by these means are expected to reveal whether further steps are necessary to protect man against the harmful effects of radiation.

The Committee recommends that the State strengthen and broaden its environmental health services to cope with the hazards arising from the rapidly changing chemical and physical properties of our environment, including research into the effects upon the health of new pollutants in the environment.

[1] The drinking water standards as they pertain to total solids suggested by the Public Health Service are a maximum of 1,000 parts of total solids per million. However, the State Board of Health is issuing temporary permits allowing 1,500 parts per million until studies of the safe limits are completed.

PERSONAL HEALTH SERVICES

Diseases such as smallpox, diphtheria, whooping cough, tetanus and poliomyelitis, which only a few decades ago took the lives of thousands of Californians every year, should occur rarely, because immunization procedures are available. Yet failure to make use of immunization procedures has been responsible for the several thousand cases of these diseases recorded by California health departments in 1960.

Studies in the State show that children in low income families with poor education are least protected by immunization. Such families rarely have regular medical care by private physicians, often neglect to use clinics established for immunization purposes, and do not readily respond to special efforts made to give them health protection.(4, 5) Isolated outbreaks of poliomyelitis in Detroit during 1958 and Rhode Island during 1960 indicate the danger of leaving substantial segments of the community relatively unprotected. Not just children, but adults of all socioeconomic strata must also keep up immunity against tetanus, poliomyelitis and other diseases.

The Committee recommends that local health departments intensify their efforts in behalf of immunization programs against poliomyelitis and other diseases to reach those segments of the population still relatively unprotected.

Besides immunization, the general periodic health examination is gradually achieving recognition as another means of preventing disease. Regular medical examination of well babies is customary in the United States. The physician examines the infant for evidence of abnormality, provides specific immunizations, reviews the growth pattern and advises the mother on feeding, behavior and other aspects of child development.

Health supervision of pregnant women also has become an accepted part of medical care. It makes possible the early detection of abnormalities that may threaten the life of the mother or child and prepares the mother for safe delivery and after-care. This kind of care has helped to reduce the maternal death rate from 71 per 10,000 live births in 1920 to 3 per 10,000 in 1958.

A periodic comprehensive health evaluation is favored by physicians, public health agencies and others as an important disease prevention measure. As in childhood, regular examinations during the later years of life can reveal chronic illness early enough to prevent disability. The pattern of regular visits to physicians for checkups does not extend into the adult and later years of life.[1]

While the ultimate aim of preventive medicine is to prevent the occurrence of diseases, the immediate hope for reducing mortality and disability from chronic diseases rests largely upon early detection, followed by diagnosis and treatment. Multiple screening, performed on large groups of apparently well persons, has much to offer as a means toward early detection.

A screening test sorts out people who appear to be well but who have previously undetected diseases such as diabetes, which can be found with urine-sugar and blood-sugar tests; tuberculosis, through chest X-ray; and cervical cancer, by means of the cytology (Papanicolaou) test for cancer. To be effective, such screening programs must be conducted under medical direction and with medical interpretation of test results. People whose test results indicate some abnormality are referred to physicians of their own choice for diagnostic study and treatment. One California study shows that about 15 percent of those screened were discovered to have previously unrecognized chronic conditions.(7)

In addition to turning up new cases of significant disease, multiple screening also serves another important purpose in preventive medicine. It brings back under treatment many individuals who may have lapsed from medical care. e.g., patients with diabetes, glaucoma and other chronic diseases for whom continuing medical supervision is so important. Multiple screening also provides an opportunity for health education. Such a health service creates a favorable climate in which to learn about the significance of overweight, sugar in the urine, high blood pressure, proper care of the eyes and many other aspects of health which it is desirable for the general public to understand.

The Committee recommends that health agencies, business, industry and professional groups, implement programs of multiple screening under medical supervision and with medical interpretation to detect important chronic diseases early.

To accelerate the application of scientific advances, many barriers must be overcome:

1. The slow diffusion of knowledge from research, which may result in conflicting medical opinion and advice and confusion among patients;
2. The failure of many intensive health education efforts, which indicates that research in health education technique is needed;
3. The shortage of personnel trained in health and educational methods;

[1] The 1958 California Health Survey revealed that 37 percent of the population had not seen a physician in the past year. Of those who did, many did not have a physical checkup.(6) Indications are that if the entire population did undergo an annual physical examination the workload of physicians would be vastly increased.

4. The bombardment of the public with fraudulent advertising and cultism;
5. The lack of or poor distribution of community services.

The Committee recommends that physicians in private practice and governmental and nongovernmental agencies which provide medical services strengthen their efforts in the health education of patients and their families.

The Committee recommends that the State bring together research specialists in education, behavioral science and health education to outline areas of needed research in health education methods and to suggest means by which such studies might be stimulated.

COMMUNITY HEALTH

The solution to many of today's important community health problems lies in the provision of needed services and depends upon public decision and action.

Fluoridation—The water supplies of only 20 California communities are fluoridated, although the value and safety of fluoridation in reducing dental caries have been scientifically proven. In a majority of elections held in California since 1951, the voters have rejected it. Studies here and elsewhere indicate no locality has effectively mobilized its health education resources on this issue in any sustained way. A successful fluoridation campaign would involve converting every physician's and dentist's office into an active health education center, introducing discussion of fluoridation into the school curriculum, assigning health department staffs to teach about fluoridation, and gaining support from voluntary agencies and volunteers.

Accidents—Intensified educational efforts are indicated if the mounting rates of disability and death from accidents are to be halted. Studies show that many such educational campaigns have failed, and analysis of the reasons is needed. It is known, for instance, that educational programs have stimulated the installation of seat belts in cars, but have not succeeded in convincing all owners to use them.

Nutrition—The young and old appear to be particularly susceptible to fraudulent advertising and the appeal of health faddists. There is a need for educating the public to distinguish between scientific and pseudoscientific information. It is also necessary to re-examine nutrition education in schools and teacher training institutions.

The Committee recommends that professional groups, health departments, schools, private agencies and civic organizations concerned about public health make an all-out effort to secure adoption by their communities of practices, such as fluoridation, which have been scientifically proved of value to health.

Community Health Services—Fragmentation and disorganization characterize many community personal health programs. Many well-intentioned efforts fail because they are undertaken or dominated by too narrow a segment of the population. Study, planning and action toward improved health services should be a continuous process engaging the efforts of a cross-section of local leadership.

How community personal health services are used depends upon their availability and the desire to use them. Experience with community programs has shown that if services are available at convenient times and places and at reasonable cost, people will use them. However, intensified health education effort is needed to reach minority ethnic groups, older people and those in lower socioeconomic brackets.

PREVENTION OF MENTAL DISEASE

Prevention of mental disorders is much less effective than prevention of disease in other areas of medicine, partly because the causes of many serious mental disorders—among them schizophrenia, manic-depressive psychosis and paranoia—remain unknown. Although the word "prevention" is often used in connection with the functions of child guidance clinics, schools and the effects of sound family relationships, the objectives of prevention in this context lack specificity.

Because the specific causes of most mental disorders are unknown, much of the work relating to prevention is based on current psychiatric theory. It is generally assumed that those suffering from mental disorders are more prone to succumb to environmental pressures which they are unable to withstand. The effects of stress situations have a marked effect on those susceptible to psychoneuroses, psychomatic conditions, personality disorders and temporary situational crises. Despite the fact that it is not known whether schizophrenia and other psychoses result from a single factor or from a combination of factors such as heredity, family stresses or infection, stress which the individual cannot handle may either precipitate a mental disorder or cause added emotional crippling. Thus, the proper handling of stress situations offers itself as a method of primary or secondary prevention of mental illness.

The development of those aspects of personality which help an individual to carry on in the face of difficulties is a legitimate part of the total mental health effort. Programs directed toward this end are sometimes referred to as "positive mental health." To this end, early conditioning situations of the newborn are

considered of extreme importance. For instance, many infants who are institutionalized for mental retardation, turn out, on closer examination, to be suffering from maternal neglect. Such emotional deprivation, if discovered early enough, is readily remedied by "tender loving care." Failure to supply the infant's emotional needs markedly retards growth and development.

The proper balance between the protection of a growing infant and the opportunities for him to expand and grow offers an important key to physical, social, emotional, spiritual and intellectual factors which are essential for healthy personality growth. From the point of view of primary prevention, and of assisting those more sensitive to external pressures to adapt, the social environment is extremely important. This includes the influences of the family, early associations with others, the school situation and increases in responsibility. These are proper targets for preventive activity, both for the prevention of specific disorders and for building strength and resistances into people to help them meet the stresses of life.

Genetic factors are increasingly recognized as very important to healthy human development. Although knowledge in this area is limited, it is hoped that with more knowledge genetic defects may be corrected to the point of preventing damage. The prenatal period of life offers an extremely important area of primary prevention of mental disorders by putting into effect what little is known concerning such factors as nutrition, damage from infection and effects of trauma. Of great importance is the preparation of the family for the as yet unborn individual.

Mental retardation has been attributed to as many as 60 different causal factors, some of which are amenable to preventive techniques. For example, it has been recently discovered that mental retardation due to phenylketonuria is caused by a particular amino acid that some infants cannot properly digest. This condition runs in families.(8) Although the incidence of this type of mental retardation is small, the metabolic error that predisposes the infant toward it can be detected by a simple and inexpensive laboratory test within a few weeks after birth.(9) It is hoped that the condition can then be prevented or checked by eliminating from the child's diet the amino acid it cannot digest.(10)

An important cause of mental retardation results from the toxic effects of infectious diseases suffered by the mother during pregnancy. German measles in the mother is extremely dangerous to her unborn child. Some have suggested that all girls should be exposed to this disease in childhood, when it is generally mild, to eliminate it as a complication during pregnancy.

Certain mental disorders result from brain damage due to circulatory difficulties, the effects of accidents and certain toxins. Although specific measures may be taken to correct or alleviate the effects of brain lesions and toxins, little can now be done to prevent the effects of arteriosclerotic damage.

Mental disorders caused by vitamin deficiencies can be prevented or checked. The effects of pellagra and primary anemia can be overcome by proper diet. Vitamin deficiency is frequently found in many elderly patients entering mental hospitals and can be rapidly relieved.

A frame of reference for the consideration of mental health factors includes these zones: (1) the prenatal, from which all persons pass as they are born, to (2) the area of healthy existence in which people remain as long as they are able to look after themselves. In this zone a person gets along without special assistance from others. When excessive stress occurs to the extent that special assistance is needed, one then enters (3) the zone of nonpsychiatric trouble. Here, the emphasis is on providing ways and means of handling the precipitating stress situation so that the normal reactions of anxiety, hostility and other emotions continue to operate in a useful way to assist in meeting obstacles and threats. Persons who can assist in this function are those engaged in such activities as public assistance agencies, home visiting personnel, public health nurses, physicians treating general disorders, those who assist in financial or employment problems, vocational rehabilitation personnel, ministers, lawyers and others.

Those who under stress and strain develop emotional reactions which cease to be useful and become, in fact, crippling and detrimental to proper functioning, and who develop a true mental disorder, are included in (4), the zone of psychiatric disease. Here they need early treatment and rehabilitation. Obviously, primary prevention does not occur in zone 4.

The consideration of prevention of mental disorders serves to emphasize our lack of information about these disorders. Such information as is available, however, suggests emphasis should be placed on the primary aspects of prevention, that is, prevention of the occurrence of the disorder. Suggested also are early treatment and rehabilitation once mental disorder occurs. In an area where the sad facts of lack of knowledge are all too apparent, emphasis on primary preventive techniques should encourage further research as of first importance.

The Committee recommends that appropriate agencies undertake further research on mental illness, including personality disorders, antisocial behavior and preschool mental health checkups.

REFERENCES

(1) *California Public Health Statistical Report, 1958*, State of California, Department of Public Health.
(2) State of California, Board of Public Health, *Standards on Mineral Quality of Drinking Water*, August 6, 1959.
(3) State of California, Department of Public Health, Morbidity Records.
(4) *California Health Survey, 1956*, Part I, Polio Survey, State of California, Department of Public Health.
(5) Public Health Service, *Poliomyelitis Vaccine Report*, September 30, 1960.
(6) State of California, Department of Public Health, *California Health Survey, 1958* (unpublished data).
(7) Weinerman, E. R., Breslow, L., et al, "Multiphasic Screening of Longshoremen with Organized Medical Follow-up", *American Journal of Public Health*, 42:1556, 1952.
(8) *Nature*, Vol. 178, pp. 1239-1240, December 1, 1956.
(9) Fellman, J. H., "Detection of Phenylpyruvic Oligophrenia with Ferric Chloride", *Journal of Neuro and Mental Disease*, Vol. 123, p. 575, June, 1956.
(10) Blainey, J. D., Gulliford, R., "Phenylalanini Restricted Diets in the Treatment of Phenylketonuria", *Archives of Diseases of Childhood*, Vol. 31, pp. 452-466, December, 1956.

Chapter 8

DIAGNOSIS AND TREATMENT

The Problem

Medicine has always been committed to the search for better methods of treating the sick. The level of care and the means of providing it change in relation to scientific, social and economic developments. New diagnostic principles and procedures, and definitive treatment where none existed a few decades ago, make the practice of medicine much more precise than formerly and offer new hope to many. Early and positive diagnosis has become imperative because many previously fatal and disabling diseases (such as certain forms of heart disease, diabetes, and some diseases of the kidney) are now curable or controllable if diagnosed in time.

The scientific breakthroughs of the past thirty years, an increasingly mobile and expanding population, use of hospitals for diagnosis as well as treatment, the high cost of medical care (for hospitals, drugs and ancillary services) and new social attitudes, have all brought about great changes in the practice of medicine.

The role of the physician as the central figure in ministering to the sick is no longer clearcut. There are now many health professions, and the large number of people in them creates a need for more efficient organization of health services. Among the ancillary services, nurses have been joined by social workers, dietitians, physical and occupational therapists, X-ray and laboratory technicians, medical records librarians and many others. For each physician there are more than eight allied health workers.

The often fearful patient, seeking help in the confusing maze of people, services and institutions, needs a physician who will take full responsibility for supervising his total medical care, who will hold his needs paramount, and who can give him confidence that every effort is being directed toward his cure. This process may involve not only the doctor's own specialty but consultation with other physicians and use of the paramedical specialties mentioned above.

Ancillary services have evolved so rapidly and in such variety and number that serious lack of coordination among them and with the physician has developed. Because of inconsistencies and confusion in the licensing of the various health professions, their functions and relationships are often unclear. These must be clarified if an integrated and harmonious health care system is to be achieved. The welfare of the patient – the crucial concern – demands intensive and dedicated effort from leaders in the health field.

Medicine has a long history of concern with professional ethics and self-discipline. In recent years, anxiety has been expressed as to whether the medical profession can discipline the small minority of physicians who engage in unethical practices or malpractice. Voluntary efforts of hospital staff organizations, county medical societies through their hospital and professional relations committees and specialists' societies aim at maintaining high professional standards. However, today no organization—either public or private—effectively exercises authority over standards of professional performance outside the hospital.

Both the profession and the public are concerned about the harmful consequences of certain practices with which a small number of doctors may be charged: failure to call in a consultant when this is indicated; performance of ill-advised or unnecessary operations, or operations by inadequately trained physicians when qualified physicians are available; use of inadequate diagnostic procedures prior to treatment; giving of unnecessary medication; failure to keep up with advances in medicine. Wasteful use of health resources and exorbitant costs result from the excessive hospitalization for which some physicians, patients and health plans share responsibility.

The Committee recommends that:

1. All Californians have a personal physician as the key element in medical care.[1]

DISSENTING COMMENT

[1] *"I think this concept too limiting. Not every physician has the administrative time or skill to organize his patients' tours through diagnostic and treatment procedures. He has come nearer to a recognition of the necessity of teamwork with other doctors and professional health personnel. He has learned from the legal and other professions that there can be partnership, or group feeling of responsibility for the individual client. I believe the old traditional idea of a 'personal physician' is giving way to a new patient-physician relationship which is an attitude of mind rather than a status, a professional concern for the health of the patient by all persons or groups who practice the healing arts."*

Stephen I. Zetterberg

2. *Early diagnosis and treatment services be covered under prepayment plans, both in and out of hospitals.*

3. *The health professions, among themselves and in cooperation with other interested groups and agencies, pursue efforts to appraise the best use of their skills, encouraging appropriate research and pilot programs to develop more efficient methods of health care through more effective use of allied health personnel.*

4. *Licensing and certification of the health professions and health institutions be the responsibility of the State Department of Public Health; that there be a licensing board for each profession, with each board having authority to set minimum training requirements for licensure; that to assist the Department, an advisory council, representing the public and the licensed professions, be created to set general policies, develop uniformity of licensure standards, coordinate the activities of the examining boards, and study and make recommendations concerning relationships among the health professions; and that the council include representation of physicians (M.D. and D.O.), dentists, nurses, hospital and nursing home administrators and the public, all on a permanent basis, and other licensed health professions on a rotating basis.*

5. *Regional Medical Disciplinary Committees, composed of five physicians, be elected by licensed physicians and surgeons in each region, and that the Boards of Medical Examiners and Osteopathic Examiners be constituted of one physician to be appointed by the Governor from each Regional Medical Disciplinary Committee; that the Regional Medical Disciplinary Committees be empowered to review and screen complaints in their respective regions and make recommendations to the Boards of Medical and Osteopathic Examiners, respectively; and that authority of the Boards should be expanded to include:*[1]

   a. *Revocation or suspension of licenses for any act of professional incompetence or for any dishonorable or unethical practice likely to deceive, defraud or harm the public.*

   b. *Review of denial or revocation of membership on hospital medical staffs, and medical service agencies, to confirm or deny the action. (Comparable authority should be granted to the licensing and certification boards for other professional health personnel.)*

6. *The Boards of Medical and Osteopathic Examiners review medical practice standards in hospitals, survey professional practices, and report findings to the State Department of Public Health, and that the Department of Public Health adopt the medical practice standards established by the Boards of Medical Examiners and Osteopathic Examiners as a part of hospital licensure requirements, and be empowered to revoke hospital licenses for noncompliance with these standards.*

7. *The California Hospital Association's "Guiding Principles for Hospitals" and the California Medical Association's "Guiding Principles for Physician-Hospital Relationships" be adopted by hospitals and their medical staffs.*[2]

DISSENTING COMMENT

[1] *"I do not concur in recommendation 5. The Power of governing should not be parcelled out to private or to selectively elected special groups. Nor do I feel that it is good administrative practice to create a number of new disciplinary boards, when the uniform hearing procedures of the Department of Vocational Standards could be used."*

[2] *"I do not concur in recommendation 7. I do not think this Committee should recommend blanket adoption by reference of proposals enacted or adopted by non-governmental private organizations. If we desire, we should set these principles out in our own text."*

Stephen I. Zetterberg

PATIENT-PHYSICIAN RELATIONSHIP

The effective practice of medicine is the art of applying the science of medicine to the care of the patient. Central to it is the relationship between patient and physician, to which both must bring significant qualities.

The patient's role lies principally in reposing that confidence in his physician which enhances treatment. From this trust flows his willingness to bring both his early physical symptoms and emotional problems to his doctor, and the conviction with which he cooperates in treatment.

In order to inspire this measure of trust, the physician must be professionally capable of caring for his patient within the limits of his field, able to recognize when he has reached those limits, and willing to turn to his colleagues for consultation. He must have genuine feeling for the sick person he is treating and for his total situation, but he must also cleave to the objectivity without which his judgment would be impaired.

The relationship between physician and patient is the living core of medicine however its services are paid for, and wherever it is practiced—whether in a field, a home, a private office, a hospital, a factory or an institution. And it is often so crucial to the ultimate outcome of treatment that all members of the ancillary medical group (the secretary, nurse, therapist and others), should be aware of how they can foster and strengthen it.

The Committee recommends that all Californians have a personal physician as the key element in medical care.

IMPORTANCE OF DIAGNOSIS AND TREATMENT IN THE SPECTRUM OF HEALTH SERVICES

Most of the work of physicians, dentists, nurses, the allied health professions and hospitals is directed to the diagnosis and treatment of illness. The California Health Survey of 1958 showed that Californians (civilian, noninstitutionalized population) averaged six physician visits a year in addition to care received in hospitals. About 80 percent of these visits to physicians were made for diagnosis and treatment, the services to which most of our available health resources are now committed.(1) Information disseminated by the popular press, radio and television about new drugs, "miracle" surgery and cures for formerly incurable diseases stimulates public demand for diagnostic and treatment services.

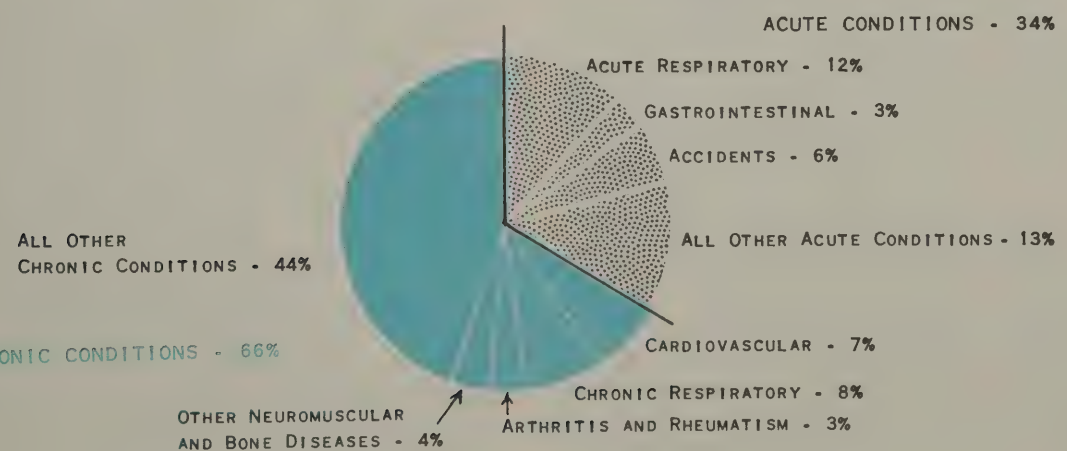
The ability of physicians to diagnose disease accurately distinguishes modern medicine most sharply from quackery and cultism. The treatment of disease has shifted from relieving manifest symptoms to getting at their causes. Good diagnosis, which takes account of both the pathologic condition and how it affects the patient's total health, depends upon the physician's skill, judgment, experience, and upon the equipment and aids available to him.

IMPORTANCE OF EARLY DIAGNOSIS AND TREATMENT

The pattern of disease in America has changed markedly. In contrast with the communicable diseases which headed the list a half century ago, diseases of the heart and blood vessels, cancer and accidents are now the leading causes of death.(2)

The means by which communicable diseases are controlled—environmental sanitation, improved gen-

PHYSICIAN VISITS FOR ILLNESS
California Health Survey, 1954-1955



eral living conditions and immunization—are not effective in controlling chronic diseases.

Safe water, milk and food have practically eliminated the dangers of many communicable diseases. These measures require little effort from individuals once public policy is established. On the other hand, control of chronic disease often involves a high degree of cooperation between the patient, his physician, the allied health professions, services, facilities and agencies concerned with medical care. One of the most important factors in the control of chronic diseases is their recognition and prompt treatment in asymptomatic or early stages. Evidence indicates that for many of the chronic diseases, early diagnosis and treatment is critical in reducing disability and premature death.

Close to 1,000 women, for example, died from cancer of the uterus in California in 1958.(2) Complete cure of this type of cancer is possible if it is diagnosed and treated early. To detect uterine cancer early requires that women, particularly those over 30, undergo periodic checkups. Better ways of persuading people to seek such early diagnostic services are essential.

One way to do this is through prepayment for early diagnostic and treatment services both in the hospital and the doctor's office. Traditionally, most prepayment plans cover only hospital and surgical expenses, but benefits gradually are being extended to pay for other services as well. Continued expansion of benefits to include out-of-hospital diagnosis and treatment would have a two-fold purpose: to encourage people to seek periodic health examinations and continuing medical care, and to reduce the need for hospitalization.

The Committee recommends that early diagnosis and treatment services be covered under prepayment plans, both in and out of hospitals.

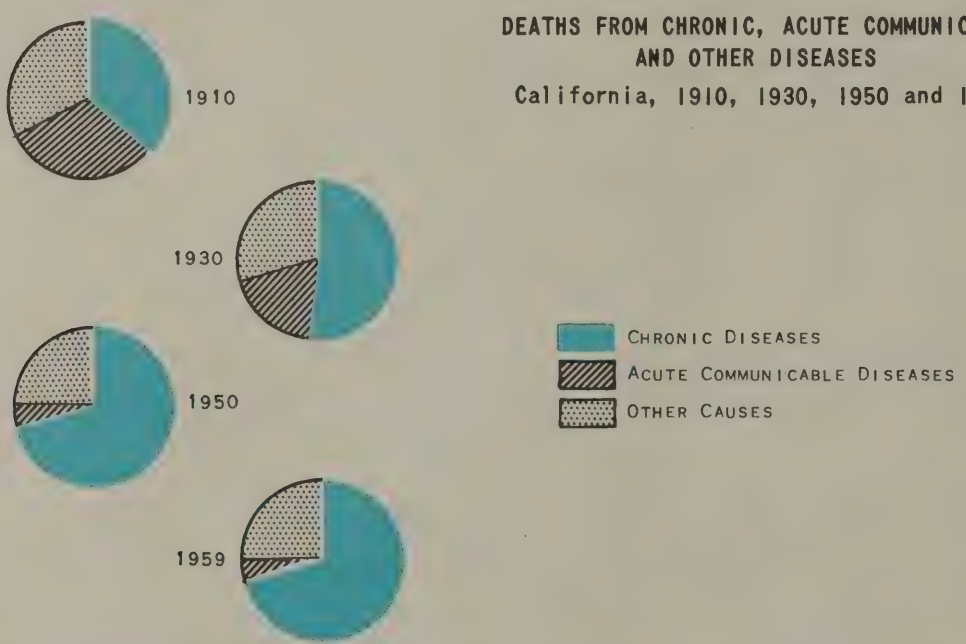
EVIDENCE OF SUBSTANTIAL AMOUNTS OF UNDETECTED DISEASE IN THE POPULATION

In any group of people there will be some with untreated disease. In their early stages, many illnesses are asymptomatic. Some ostensibly healthy people are actually in the early stages of illness. For this reason, all people must be educated to seek regular medical examination. Also, some persons think their symptoms too trivial to warrant seeing a physician. Ignorance about the significance of symptoms, fear, superstition, lack of money, inaccessibility of medical services and cultural factors may also inhibit people from obtaining medical care. Periodic health examinations, multiple screening under medical direction and with medical interpretation, and other methods of early detection can uncover much serious illness in the early stages.

Some evidence indicates significant amounts of undiagnosed disease. In one study, 40 percent of 1,513 business executives were found to have previously undetected disease. The study team estimated that over one-half of these conditions could cause death or major disability if allowed to continue unchecked.(3)

In Hunterdon County, New Jersey, between 1952 and 1954, complete clinical evaluations were performed on a selected population sample. The examining team found that for 60 percent of the medically disabling conditions they diagnosed, insufficient or unsatisfactory care had been received during the preceding year. Unwillingness of patients to follow the

DEATHS FROM CHRONIC, ACUTE COMMUNICABLE AND OTHER DISEASES
California, 1910, 1930, 1950 and 1959



recommendations of their own physicians frequently was a reason medical care had not been received. In other instances, patients had not been diagnosed during the previous year and thus had not had proper care. The evaluation team also found that 13 percent of the conditions had been previously diagnosed incorrectly. They estimated that although only 6 percent of the medically disabling conditions could have been altogether averted, three out of ten of the conditions they diagnosed could have been prevented from reaching the stage in which they were found at the time of clinical examination.(4)

MORE EFFECTIVE USE OF ALLIED HEALTH PERSONNEL

A study committee of the American Medical Association found that " . . . the physician of today is confronted with the most complex and variable pattern of relationships in the health professions that has ever existed". In 1900, three out of every five professional health workers were physicians; in 1950, one in five were physicians; by 1955, there were eight workers in health services for each physician. (5) As a result of scientific and technical progress, many new health occupations have been emerging. Besides physicians, dentists and nurses, health manpower now includes, among others, research scientists, technicians of various kinds, psychologists, social workers, physical therapists, dietitians and sanitary engineers.

With expanding population and increased demand for medical care has come a threatened shortage of physicians. In recent years physicians have tended to delegate certain functions to allied professions. Such use of allied personnel has developed somewhat erratically under the pressure of need, and depends upon the availability of assistants, developments in medical technology and changes in the form of medical practice.

Nonprofessional responsibilities have also been added to existing functions. The professional nurse, in addition to responsibility for bedside care and direct assistance to physicians, frequently must also act as administrator or teacher, and keep abreast of evermore complex technical procedures.

The development of new ancillary services has been so rapid that the professions often are slow to assimilate them. Although dentists, for instance, can increase productivity by using dental hygienists to assist them, some dentists have not availed themselves of such help. The severe shortages of health manpower make it essential that the medical and related professions come to grips with the problem of using allied health workers wherever appropriate.

NEW EMPHASIS IN TRAINING OF HEALTH PERSONNEL NEEDED

A serious problem in educating allied health workers is how to relate the curriculum to the realities of day-to-day job responsibilities. Nowadays, patterns of patient care can change rapidly and training is apt to lag behind the latest trends. Most new graduates in the health fields are not prepared to work effectively with other allied health workers although the concept of the "health team", in which every member has a recognized function, is gaining widespread acceptance.

Interprofessional communication would also be facilitated if the jargon and vocabulary which each health profession tends to develop were clarified. If education is to be more effectively related to the mainstream of medical practice, liaison between the practicing professions and educators must be strengthened.

Pilot projects, sponsored by governmental and nongovernmental agencies, are needed to delineate the appropriate relationships among allied health occupations to develop more effective methods for using personnel in these occupations. Nursing has made considerable progress in training nurses on several levels of professional skills. Similar programs should be undertaken in other health fields. Medical centers, too, can make a great contribution by developing programs for integrating the functions of the many professions they train which comprise the health team.

The Committee recommends that the health professions, among themselves and in cooperation with other interested groups and agencies, pursue efforts to appraise the best use of their skills, encouraging appropriate research and pilot programs to develop more efficient methods of health care through more effective use of allied health personnel.

NEED FOR COORDINATING LICENSURE OF HEALTH PROFESSIONS AND FACILITIES

The California laws regulating licensure of the health professions pose many unresolved issues. Some of the health professions are licensed by the State, others are certified or registered and some come under no legal authority. Licensure laws prohibit unlicensed persons from practicing, but certification procedures merely prohibit practitioners lacking a certificate from

using authorized titles. (For example, only certified psychologists may call themselves psychologists.)

Certain practitioners are not required to be under the direction or supervision of a physician and these professional groups practice independently of physicians, e.g., optometrists and podiatrists. Failure to agree on their functions and level of professional skill results in practice isolated from medicine. In general, these groups are excluded from hospital staffs. When licensing and certification of a single profession coexist, as in the case of physical therapy, confusion often results.

At present, 9 professional boards in the Department of Professional and Vocational Standards have authority over 17 professional groups. There is also a separate Board of Osteopathic Examiners.(6) (The Department of Public Health is responsible for licensing medical laboratory technologists and clinical bioanalysts.) These boards function independently of one another, and without uniform policies or criteria to guide them in determining licensure or certification qualifications. Neither do the regulations clearly delineate the scope within which the various professions may practice. No mechanism exists for coordinating the objectives and activities of the various boards.

California's hospitals and nursing homes are licensed by the State Department of Public Health. Licensure regulations principally involve standards for physical plants and equipment; standards relating to medical practice in such institutions are minimal.

Because the increasing interdependence of medical facilities and the health professions makes it important to clarify and standardize licensure procedures, the Committee believes that a single health agency, the State Department of Public Health, should be given administrative responsibility for licensing and certifying the health professions, hospitals, nursing homes and related health care facilities.

The Committee recommends that licensing and certification of the health professions and health institutions be the responsibility of the State Department of Public Health; that there be a licensing board for each profession, with each board having authority to set minimum training requirements for licensure; that to assist the Department, an advisory council, representing the public and the licensed professions, be created to set general policies, develop uniformity of licensure standards, coordinate the acivities of the examining boards, and study and make recommendations concerning relationships among the health professions; and that the council include representation of physicians (M.D. and D.O.), dentists, nurses, hospital and nursing home administrators and the public, all on a permanent basis and other licensed health professions on a rotating basis.

QUALITY OF DIAGNOSTIC AND TREATMENT SERVICES

In the United States, voluntary professional organizations and allied groups play an influential role in setting standards for controlling the quality of medical care. Many are active in upgrading standards of professional qualifications and performance. In particular, national specialty boards have advanced the levels of professional skill in medicine and dentistry. Established by the professions, these boards certify specialists who meet their standards of education, knowledge and experience.

The organized medical staff in hospitals establishes procedures and qualifications for appointment to the staff, defines the areas of professional competence of its members, requires consultation in difficult cases, and establishes committees to review professional services and level of medical performance in the hospital. The Joint Commission on Accreditation of Hospitals sets standards for improving patient care in accredited hospitals. The recently developed "Guiding Principles for Physician-Hospital Relationships" of the California Medical Association states:

> "Rules and regulations having their origin in these committees have one main objective—the insuring of the best possible medical care for the patient in the safest and most economical manner. Each physician has a responsibility to be an active participant in the work of any of the committees to which he has been appointed. Of equal importance, each physician must make it his personal responsibility not only to comply with decisions made by the staff on recommendations of its committees, but to insist that all other physicians also comply. He must be willing to call a colleague to an accounting if he thinks the colleague has erred. Likewise, he too, by reason of his staff membership, must be governed by the same conditions."

Another method for measuring and improving the quality of medical care in hospitals is being developed by the Commission on Professional and Hospital Activities, sponsored by the American College of Surgeons, American College of Physicians, American Hospital Association and the Southwestern Michigan Hospital Council. Under this system, diagnosis and treatment of conditions for which standards of management are widely accepted is evaluated from medical records analyzed by a committee of the hospital medical staff. Two California hospitals are among the 136 in the nation participating in this pilot program.(7)

DIFFICULTIES IN EXERCISING MEDICAL DISCIPLINE

Although progress has been made in upgrading care in those general hospitals which have instituted the procedures described above, no systematic approach has been made to the problem of controlling quality of care in physicians' offices, patients' homes and outpatient clinics.

In California the grievance committees of county medical societies attempt to discipline physicians who engage in unprofessional practices harmful to the public. Medical societies are critical of physicians who fail to call in a consultant when this is indicated; who perform operations for which their training is inadequate when qualified physicians are available; who operate unnecessarily; who fail to carry out adequate diagnostic procedures prior to treatment or surgery; who prescribe unnecessary or incorrect medication; and who fail to keep abreast of advances in medicine. Unethical practices such as fee-splitting, overcharging and excessive hospitalization lead to wasteful use of resources and to exorbitant costs. Although only a small number of physicians engage in such practices, the profession feels that these must be completely eliminated. However, efforts of voluntary medical groups to control such activities are hampered by lack of authority over physicians who do not choose to comply. Attempts to enforce disciplinary measures in cases of professional incompetence have resulted in suits being brought against hospital medical staffs and county and State medical societies. Consequently, medical bodies have become increasingly reluctant to pursue disciplinary action.

To remedy the situation, the Boards of Medical and Osteopathic Examiners need authority to discipline incompetent physicians. The Boards ascertain the professional competence of applicants at the time of licensure. However, once a license is issued the Boards are powerless to suspend or revoke it for subsequent professional incompetence. The Boards' disciplinary authority to suspend licenses is limited largely to criminal offenses, e.g., narcotics addiction, criminal abortion, or crimes involving moral turpitude. A license also may be suspended when a licentiate is adjudicated insane or mentally ill, or when a physician voluntarily commits himself to a State hospital for treatment of a mental illness. The Boards are powerless to act even when malpractice or gross professional incompetence has been demonstrated.

Other states have granted broader powers to their examining boards. In Washington, the Medical Board which is elected by licensed physicians may revoke licenses when repeated acts of gross misconduct have been proven.(8) Delaware recently enacted legislation broadening the powers of its medical and osteopathic boards.(9)

The Committee urges broadening the disciplinary powers of the Boards of Medical Examiners and Osteopathic Examiners. For this purpose the State should be divided into a number of regions, each having its own Regional Medical Disciplinary Committee (one for M.D. and another for D.O. physicians) composed of five physicians elected by licensed physicians and surgeons in the respective regions. These Regional Medical Disciplinary Committees should be empowered to review complaints against any licensed physicians, to hold official hearings, and recommend appropriate action to the Boards of Medical and Osteopathic Examiners. The Boards of Medical Examiners and Osteopathic Examiners should each be constituted of one physician from each regional committee to be appointed by the Governor, and empowered to revoke licenses for malpractice and unethical conduct. Also, the boards should have similar powers to confirm or deny the actions of hospital staffs in dropping physicians from membership.

The Committee recommends that Regional Medical Disciplinary Committees, composed of five physicians, be elected by licensed physicians and surgeons in each region, and that the Boards of Medical Examiners and Osteopathic Examiners be constituted of one physician to be appointed by the Governor from each Regional Medical Disciplinary Committee; that the Regional Medical Disciplinary Committees be empowered to review and screen complaints in their respective regions and make recommendations to the Boards of Medical and Osteopathic Examiners, respectively; and that authority of the Boards should be expanded to include:

a. *Revocation or suspension of licenses for any act of professional incompetence or for any dishonorable or unethical practice likely to deceive, defraud, or harm the public.*

b. *Review of denial or revocation of membership on hospital medical staffs and medical service agencies, to confirm or deny the action. (Comparable authority should be granted to the licensing and certification boards for other professional health personnel.)*

STANDARDS FOR HOSPITALS

More than half of California's general hospitals with 25 beds or more (the minimum needed for accreditation) are not accredited by the Joint Commission on Accreditation of Hospitals. These unaccredited hospitals include almost a quarter of the State's general hospital beds.(10) Although there may be many reasons for a hospital to be unaccredited, it should be borne in mind that the standards of the Joint Commission are minimal. The public needs to be better informed about the purpose of accreditation.

The Committee recommends that the Boards of Medical and Osteopathic Examiners review medical practice standards in hospitals, survey professional practices, and report findings to the State Department of Public Health, and that the Department of Public Health adopt the medical practice standards established by the Boards of Medical Examiners and Osteopathic Examiners as a part of hospital licensure requirements, and be empowered to revoke hospital licenses for noncompliance with these standards.

The Committee recommends that the California Hospital Association's "Guiding Principles for Hospitals" and the California Medical Association's "Guiding Principles for Physician-Hospital Relationships" be adopted by hospitals and their medical staffs.

NEED FOR PUBLIC EDUCATION

The intelligent use of health services and resources requires an informed public. Mass communication media frequently carry articles and programs on health which create unrealistic expectations on the public's part about the power of doctors to cure illness. Problems arise when patients with only a little bit of knowledge demand treatment that is either untested or not appropriate to their conditions.

People in the health professions are in a strategic position to educate patients about health and illness, but this opportunity is often neglected. Many misconceptions and fears originate from the failure of physicians and nurses to take the time to do an adequate educational job.

CONTINUING EDUCATION OF PHYSICIANS AND HEALTH PERSONNEL

Postgraduate education should be a lifetime pursuit of physicians; none can practice competently without keeping abreast of medical progress. Formal courses offered by medical schools, hospitals and medical associations, scientific meetings and conferences, hospital staff meetings, medical journals and books, consultations with colleagues, and information supplied by pharmaceutical houses are some of the means by which physicians keep up-to-date.

In 1960, the 266 postgraduate courses offered in California had 31,276 enrollments. Taught by almost 3,000 faculty or speakers, those attending spent a total of 575,000 hours in such courses.(11) While many physicians avail themselves of postgraduate educational opportunities, those who do not should be encouraged to do so.

REFERENCES

(1) State of California, Department of Public Health, California Health Survey, 1958 (unpublished data).

(2) *California Public Health Statistical Report, 1958*, State of California, Department of Public Health.

(3) Elsom, K. A., Schor, S., Clark, T. W., Elsom, K. O., and Hubbard, J. P., "Periodic Health Examination", *J.A.M.A.*, Vol. 172, No. 1, (January 2) 1960, pp. 5-10.

(4) Trussell, R. E., and Elinson, J., "Chronic Illness in a Rural Area", *Chronic Illness in the United States*, Vol. III, 1959.

(5) American Medical Association; Proceedings of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services.

(6) *California State Government; A guide to its organization and functions*, State of California, Department of Finance, Organization and Cost Control Division, 1958.

(7) Direct correspondence with Slee, Vergil N., Director, Commission of Professional and Hospital Activities, June 9, 1960.

(8) State of Washington, Medical Disciplinary Act, and direct correspondence with the Medical Disciplinary Board, State of Washington, July 27 and August 11, 1960.

(9) State of Delaware, House Bill H 583, 1959.

(10) State of California, Department of Public Health, Bureau of Hospitals.

(11) California Medical Association, Committee on Postgraduate Activities, Survey of Postgraduate Courses and Continuation Educational Meetings given in California, July 1, 1959-June 30, 1960 (unpublished tables).

Chapter 9

REHABILITATION

The Problem

Rehabilitation has not yet captured the public imagination to the same extent as "miracle drugs," yet it holds the same miraculous potential for restoring the seemingly hopelessly ill or disabled to self-sufficiency and even fruitful endeavor.

Thousands of incapacitated men and women in State mental hospitals, county hospitals, chronic disease hospitals and nursing homes are reduced simply to waiting for death, at enormous public expense, largely because rehabilitation services are inadequate in number and scope. The physical conditions of contracture and atrophy, and the psychic conditions of depression and passivity seen in so many institutional patients are not always due to the natural process of the patient's disease, but rather to the immobilization of body and spirit which results from insufficient and often misguided treatment.

Urgently needed are more restorative services directed toward aiding each disabled person to achieve that meaningful measure of independence of which he may be capable.

The Committee recommends that:

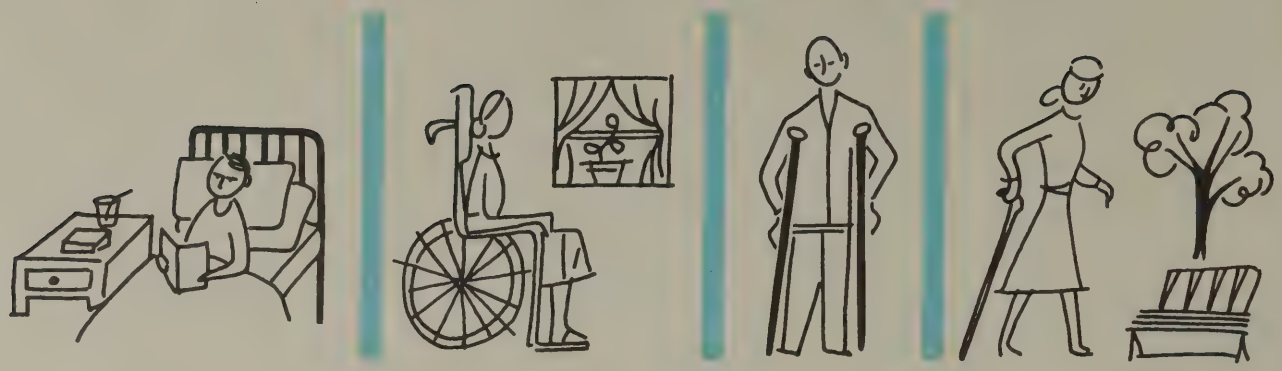
1. *State subvention be offered to county and city agencies for rehabilitation services to the needy disabled and aged.*
2. *The principles of rehabilitation be included in the educational programs of the health professions by professional schools, professional societies, hospitals, nursing home associations, health departments and voluntary organizations.*
3. *Training centers for rehabilitation specialists be expanded and recruitment intensified, and that State and junior colleges, in cooperation with appropriate rehabilitation services, develop new training programs for physical and occupational therapists.*
4. *The State Department of Public Health, in allocating Federal and State matching funds, approve only grants for construction of integrated facilities.*
5. *Hospital rehabilitation facilities, staffed by teams of specialists, be operated as separate units in hospitals, and that charges for rehabilitation treatment be limited to the actual costs of only those particular services.*
6. *The State establish a program, similar to Crippled Children Services, for evaluation and rehabilitation of severely disabled adults, the State to finance the costs of diagnosis and those treatment costs which are over and above the individual patient's ability to pay.*
7. *Agencies which license institutions for the aged promote rehabilitation in these institutions and provide training for their staffs, and that State funds should be available for this purpose.*
8. *Public assistance applicants and recipients be screened for disability and rehabilitation initiated when indicated, and that welfare agen-*

cies which pay for nursing home care offer financial incentives to encourage nursing home operators to provide rehabilitation.

9. *The State employ the qualified disabled and promote their employment in industry by underwriting insurance for subsequent injuries attributable to or aggravated by the disability.*

10. *An Interdepartmental Coordinating Council for State Programs in Rehabilitation be established to sponsor research, demonstration projects, evaluation studies and educational programs in rehabilitation. The Council should include the State Directors of Education, Employment, Mental Hygiene, Public Health, and Social Welfare, or their representatives, and be assisted by a permanent staff of specialists in medical, social, psychological and vocational aspects of rehabilitation, housed in the State Department of Public Health.*

11. *Workmen's Compensation Laws be amended to cover rehabilitation costs, and that cash awards for permanent disability not be adversely affected by a patient's acceptance of restorative services.*



WHO ARE THE DISABLED?

The disabled, inside and outside institutions, are those who suffer from arthritis, congenital defects, mental illness, injuries from accidents or strokes, heart disease, neuromuscular diseases (e.g., poliomyelitis, multiple sclerosis) or other such incapacitating conditions.

In 1958, approximately 375,000 Californians outside of institutions suffered disabilities which cut them off from normal activity.(1) Over 100,000 are in long-term facilities with an estimated 60,000 age 65 or over (about five percent of the aged).(2, 3)

WHAT IS REHABILITATION?

Rehabilitation attempts to overcome the social isolation of incapacitated people, reduce their psychological dependency and retrain them physically for employment or self-care. And today it is considered as important a health service as prevention, diagnosis and treatment.

The successfully rehabilitated is the person who has achieved his own best potential, in terms of health, productivity and self-support, and his treatment must be total if it is to be most effective.

In the interests of its broad goals, rehabilitation embraces the know-how and training of physicians, nurses, dentists, social workers, psychologists, counselors, and a variety of therapists, and implements numerous social measures. Successful amputation of a leg, for example, does not end with the healing of the stump. The amputee needs an artificial limb, training in its use, social services designed to reassure him about his family's welfare, vocational counseling and re-education if his former work called for a two-legged man, and psychotherapeutic help in accepting himself as a disabled person.

Medical treatment for the acute phases of illness is distinct from rehabilitation, but informed people in both fields know they are not mutually exclusive. Immediate attention to simple restorative techniques such as positioning, splinting and turning of stroke patients can prevent bedsores, contractures of joints, muscle atrophy, incontinence and osteoporosis—conditions often more disabling than the initial disease.

WHAT REHABILITATION CAN DO

During 1956-1957, of the 53 patients who completed rehabilitation training at the San Mateo County Crystal Springs Rehabilitation Center, 41 were able to return to their homes at a savings to the county of $67,790 a year. Twelve of them were able to take full-

PRIMARY DIAGNOSIS OF PATIENTS IN NURSING HOMES

time jobs, at a savings to the county of $33,072 a year.(4)

At the Rancho Los Amigos Hospital in Los Angeles County, between November 1955 and November 1957, intensive rehabilitation with a sample of 85 chronically ill patients reduced the post-acute care period from three and a half years to six and a half months, at a savings to the county of about $7,640 for each patient.(5)

A rehabilitation project at Napa State Hospital, geared to intensive treatment and rehabilitation of selected older patients, has shown that many elderly people are in State mental hospitals because community medical care and restorative services are inadequate.(6)

The management of hemiplegia (paralysis of one side of the body) was the most frequent disabling condition found among patients in California nursing homes in a 1954 study.(7) Yet one study showed that, with treatment, 84.5 percent of patients with hemiplegia were able to walk again, or could walk with the aid of appliances, and 88.1 percent regained partial or complete ability to care for themselves.(8)

Although the work of the county hospitals clearly demonstrates the usefulness of their rehabilitation services for elderly and severely handicapped patients, only an estimated 10 percent of 9,000 long-term beds now can be allocated to rehabilitation.(9) Thus, many nonpsychotic senile patients who could be helped in more appropriate community facilities vegetate in State mental institutions.

The Committee recommends that State subvention be offered to county and city agencies for rehabilitation services to the needy disabled and aged.

EDUCATION OF THE HEALTH PROFESSIONS

The principles of rehabilitation are not sufficiently emphasized in the education of doctors, nurses and other health personnel. Consequently, they are unaware of the many simple rehabilitation techniques that can be performed by the doctor in his office, the visiting nurse, the social worker and other members of the health professions. Health workers should be trained to recognize when specialized skills are needed and to refer patients for appropriate care.

In California, practicing professional nurses have benefited greatly from a series of training workshops at the Fairmont Hospital Rehabilitation Unit (Alameda County), financed by the State Department of Public Health. Sporadic efforts, which reach only a few, have also been made by other county hospitals to train physicians, nurses, therapists and hospital administrators in rehabilitation principles.

The Committee recommends that the principles of rehabilitation be included in the educational programs of the health professions by professional schools, professional societies, hospitals, nursing home associations, health departments and voluntary organizations.

SHORTAGE OF REHABILITATION PERSONNEL

The expansion of rehabilitation services in California has been delayed by severe shortages of rehabilitation personnel. Although many are recruited from outside the State, a large number of budgeted positions remain unfilled. The Office of Vocational Rehabilitation supports a small number of rehabilitation traineeships in counseling, medicine, occupational therapy, social work, speech pathology, audiology and prosthetics, but many more young people must be recruited for this work. Junior colleges, which could train physical and occupational therapy assistants, presently train none.

The Committee recommends that training centers for rehabilitation specialists be expanded and recruitment intensified, and that State and junior colleges in cooperation with appropriate rehabilitation services, develop new training programs for physical and occupational therapists.

FACILITIES AND SERVICES

Rehabilitation centers, which are relatively new health facilities, concentrate in one area the specialized skills, services and equipment related to treatment of the disabled. These centers attempt to create a warm atmosphere rather than the impersonally efficient atmosphere such as often prevails in hospitals. The patient's sense of self and dignity is held important and his preferences in such matters as clothing, activities and friendships are taken into account. Ideally, the centers should be affiliated with a community general hospital for easy access to special medical services such as diagnostic X-rays, laboratory tests or surgery which rehabilitation patients sometimes need.

Rehabilitation should not be done piecemeal or by category, but by coordinated effort and integrated programs for all the disabled. Often specialized facilities in California—such as those for the blind, cerebral palsied, and postpolio victims—are separate from other sources of medical care. Scattered community resources foster duplication of services, and can result in failure to provide a sufficiently broad range of care. For example, although the services of a speech therapist are often necessary in the rehabilitation of hemiplegics, aphasic children, the deaf, cerebral palsied and other disabled persons, a speech therapist might be

available only to the deaf, at their separate facility, and not to the disabled in other centers.

The Committee recommends that the State Department of Public Health in allocating federal and State matching funds, approve only grants for construction of integrated facilities.

REHABILITATION UNITS—CONTINUITY OF CARE

Because many disciplines are involved in rehabilitation, the "team" approach has facilitated communication and cooperation among rehabilitation workers, whether in special centers, hospitals, outpatient departments or patients' homes. Without close cooperation, the members of the "team" often find themselves working at cross purposes and without a common understanding of specific goals.

The services of physicians, visiting nurses, social workers, vocational counselors and mobile rehabilitation teams, are an important aspect of community rehabilitation services, and constitute the continuity of care so vital to the rehabilitation patient after his discharge from the hospital.

Independent multiple disability centers and rehabilitation units within hospitals both have their place. Because construction and operation of rehabilitation facilities are so costly and shortages of personnel so critical, improved organization of existing rehabilitation facilities is imperative.

Many disabled persons now in rehabilitation centers for single diseases could be cared for in general hospital rehabilitation units. Such units in general hospitals should be independent services, with separate personnel. Charges for these expensive services should be based on rehabilitation costs only and accounted for separately from other hospital service costs.

The Committee recommends that hospital rehabilitation facilities, staffed by teams of specialists, be operated as separate units in hospitals, and that charges for rehabilitation treatment be limited to the actual costs of only those particular services.

FINANCING REHABILITATION SERVICES

Crippled children and disabled persons with vocational potential may be assisted by State agencies. The indigent and medically indigent are eligible for care in county hospitals, but only a few counties have adequate programs. Public facilities are therefore overcrowded with physically and mentally disabled patients, many of whom receive only custodial care because funds and personnel for active rehabilitation programs are lacking. There are, however, private rehabilitation facilities in California which are not being fully used because too few people can afford costly rehabilitation treatment. Means for making full use of these facilities should be explored.

At present, many people are ineligible for rehabilitation services until their resources are exhausted, at which point they become dependent on public assistance. Often, the need for lengthy public assistance would have been unnecessary had restorative services been available.

The Committee recommends that the State establish a program similar to Crippled Children Services for evaluation and rehabilitation of severely disabled adults, the State to finance the costs of diagnosis and those treatment costs which are over and above the individual patient's ability to pay.

NEEDS OF NURSING HOMES AND RELATED LONG-TERM CARE FACILITIES

As of March 1960, 667 nursing homes with a total of more than 16,000 beds were licensed by the State Department of Public Health.(10) More than one-third of these have fewer than 10 beds. The 1954 survey showed that 90 percent of their patients are over 65 years of age, and the majority severely disabled.(7) Since 1947, the number of nursing home beds in the State has doubled. Although great improvements have been made in their physical plant and administrative standards, nursing homes, along with boarding homes and institutions for the aged, provide almost no restorative services.

The Committee recommends that agencies which license institutions for the aged promote rehabilitation in these institutions and provide training for their staffs, and that State funds should be available for this purpose.

PUBLIC ASSISTANCE AND REHABILITATION

Much legislation has been passed to aid the disabled, usually by providing cash benefits for loss of income resulting from disability. Important programs include Workmen's Compensation, disability benefits under old age, survivors and disability insurance, payments to war veterans with service-connected disabilities, public assistance programs (aid to the needy disabled, aid to needy children of incapacitated fathers, aid to the needy blind), and California's unemployment compensation disability plan.

All of these public programs should encourage rehabilitation and make it widely available. Unfortunately, health appraisal is not included in most public assistance programs, although several studies have shown that the disabled welfare recipients profit from restorative services.

A problem frequently arises when a rehabilitated worker, who has returned to work, earns too little to maintain himself and his family, and yet is ineligible

for public assistance because he is employed. Measures should be taken to tide such newly rehabilitated persons over until their earning capacity is adequate.

About a third of the patients in nursing homes in California depend on public assistance payments to meet a part or the total cost of their care.(7) These payments, in most counties, are far below what is necessary to provide skilled nursing and ancillary services for aged, severely disabled patients. Adequate rehabilitation and activity programs in nursing homes have not been developed. Welfare payments for nursing home patients should be sufficient to provide services which encourage ambulation, activity and self-care.

The Committee recommends that public assistance applicants and recipients be screened for disability and rehabilitation initiated when indicated, and that welfare agencies which pay for nursing home care offer financial incentives to encourage nursing home operators to provide rehabilitation.

EMPLOYING THE DISABLED

A problem for the rehabilitated person is limited employment opportunity. Many employers demand qualifications which bear little relation to the demands of the job, some fear increased insurance premiums, and others lengthy periods of absenteeism.

The Vocational Rehabilitation Service and the State Department of Employment have shown that rehabilitated persons do perform reliably in a wide range of employment situations. The California State Personnel Board currently analyzes jobs in State government with regard to their suitability for various kinds of handicapped employees.

The Committee recommends that the State employ the qualified disabled, and promote their employment in industry by underwriting insurance for subsequent injuries attributable to or aggravated by the disability.

THE STATE'S PROGRAMS

The State Departments of Employment, Social Welfare, Public Health, Mental Hygiene and Education are each responsible for some aspect of rehabilitation services, but their programs are separately administered and organized, with the result that there is lack of coordination and overlapping of services. For example, the Departments of Education, Public Health, and Social Welfare all currently provide services for different categories of blind patients.

For the past 10 years, directors of departments concerned with programs for the blind have been exchanging information and initiating studies directed toward greater coordination. Other rehabilitation programs might effectively pattern themselves on this plan.

The Committee recommends that an Interdepartmental Coordinating Council for State Programs in Rehabilitation be established to sponsor research, demonstration projects, evaluation studies and educational programs in rehabilitation. The Council should include the State Directors of Education, Employment, Mental Hygiene, Public Health, and Social Welfare, or their representatives, and be assisted by a permanent staff of specialists in medical, social, psychological and vocational aspects of rehabilitation, housed in the State Department of Public Health.

REHABILITATION AND WORKMEN'S COMPENSATION

While some insurance companies have been slow to adopt the philosophy of rehabilitation in their dealings with disabled workers, others have done pioneering work in this field.

In California, Workmen's Compensation Insurance provides the disabled worker with complete medical benefits for injury or illness arising from or incurred during the course of employment. The State Compensation Insurance Fund has set up a Department of Rehabilitation. Within two weeks of diagnosis, all cases of paraplegia, quadraplegia, hemiplegia, amputations and industrial blindness are referred to this department, whose advisers then work with the injured claimant insured by the State funds, his family, and his employer, to develop a suitable rehabilitation program with provision for gainful employment. Every attempt is made to keep claims adjustment functions separate from the rehabilitation program.

The Liberty Mutual Insurance Company, a private carrier of Workmen's Compensation Insurance, has also done an outstanding job in rehabilitation. Professional nurses are employed by this company to coordinate the medical services to injured workers and to offer counseling.

The Committee recommends that Workmen's Compensation Laws be amended to cover rehabilitation costs, and that cash awards for permanent disability not be adversely affected by a patient's acceptance of restorative services.

REFERENCES

(1) *Health in California*, State of California, Department of Public Health, 1957.

(2) *Hospital for California, 1958*, State of California, Department of Public Health, Bureau of Hospitals.

(3) State of California, Department of Public Health, *Health Implications of Institutionalized Care for the Aged* (December 10), 1958 (mimeo.).

(4) Chope, Harold D.; "Rehabilitation in San Mateo', *Public Health Reports*, Vol. 73, No. 1, January 1958, pp. 42-45.

(5) Affeldt, J. E., Nickel, V. L., Perry, J., Kriete, B. C.; *Intensive Rehabilitation in a Chronic Disease Hospital: Recent Experience at Rancho Los Amigos Hospital.*

(6) Todd, R. L.; "Special Program for Elderly Patients', *Napa Quarterly*, Vol. 1, No. 2.

(7) State of California, Department of Public Health, Bureau of Hospitals. "Nursing Homes in California", *California's Health*, Vol. 12, No. 22, May 15, 1955. pp. 173-176.

(8) Lee, P. R., et al., "An Evaluation of Rehabilitation of Patients with Hemiparesis or Hemiplegia, Due to Cerebral Vascular Disease". (New York University, Bellevue Medical Center, Institute of Physical Medicine and Rehabilitation.) *Rehabilitation Monograph XV*, 1958.

(9) State of California, Department of Public Health, Bureau of Hospitals, *County Hospitals*, March 31, 1960 (basis for estimate).

(10) State of California, Department of Public Health, Bureau of Hospitals (unpublished data).

Chapter 10

POPULATION GROUPS WITH SPECIAL HEALTH PROBLEMS

The Problem

To assure appropriate health care for the entire population, it is necessary to examine the adequacy of services for groups with special needs. Organizing California's health programs involve making special adjustments wherever the problems are urgent.

There are many population groups with special health problems that should be studied. The Committee, because of its limited time for such study, makes explicit recommendations for only six such groups:

a. The aged population, 65 years and older;
b. Prematurely born infants, and children with seriously handicapping conditions;
c. Public assistance recipients;
d. Ethnic minorities;
e. Seasonal agricultural workers;
f. Delinquents and criminals.

The Committee recommends for all these groups that:

1. *Action be taken to remedy existing gaps in public medical care, and to establish more uniform financial and residence eligibility requirements throughout the State.*

2. *Appropriate agencies of State and local governments actively encourage the maximum use of available health services.*

3. *Appropriate agencies of the State and local governments, voluntary agencies and professional associations concerned with health, plan and conduct a coordinated health education program directed toward population groups with special health needs.*

For the Aged

4. *A portion of federal-state matching funds under HR 12580 be used to expand screening and health evaluation programs.*

For Children

5. *The State provide funds to designated community general hospitals to support units for the care of premature infants.*

6. *The State broaden the Crippled Children Services to permit inclusion of all seriously handicapping conditions of children, at the discretion of the State Department of Public Health.*

For Public Assistance Recipients

7. *The State amend the public assistance programs to include financial assistance and medical treatment for nonhospitalized mentally ill patients on the same basis as other needy persons receiving medical care in the local community.*

For Ethnic Minorities

8. *School authorities and counselors, at all levels of education, seek out and encourage students of minority groups to pursue health careers and induce them to apply for available scholarships.*

9. *Private foundations award more scholarships for training in the health professions for which qualified minority youths would be eligible.*

10. *Local public health agencies recognize that health services are more effective in meeting total community needs when administrative as well as program staffs include competent members of the major ethnic minority groups in the population.*

For Seasonal Agricultural Workers

11. *The State provide financial support for locally-administered health services for resident and migrant seasonal agricultural workers.*

12. *The State and other appropriate groups study the feasibility of prepayment health plans and inclusion of seasonal agricultural workers in the Unemployment Compensation Disability Program.*

For the Delinquent and Criminal

13. *The State provide more funds to appropriate State departments for adequate psychiatric treatment of adult and juvenile delinquents.*

Even a cursory examination of these population groups with special health needs reveals that meeting these needs is beyond the scope of health agencies and disciplines as they are now organized. Society has failed to inform, engage and serve these groups.

When we shelve older people, their health problems become more acute. When we isolate certain categories of seriously handicapped children, we fail to provide them with equal opportunities for health service. When we segregate certain ethnic minorities—Californians of Mexican, Negro, Oriental or American Indian heritage—their health problems are complicated through neglect. When we consider seasonal agricultural workers ineligible for health services, we not only compound their health problems, but also endanger the health of others. When we think that persons who receive public assistance want only to be dependent, we tend to fail to provide them with the rehabilitation that could reduce their dependency. When we shun delinquents and criminals—usually forgetting that most of them return to society after being institutionalized—we fail to provide the kind of rehabilitation that helps them to function as healthy and responsible citizens. Thus, because we neglect the health needs of certain population groups, they become community health problems.

There are, of course, other factors that should be considered in a study of conditions associated with certain population groups having special health needs.

1. Some of these population groups (the aged, ethnic minorities, seasonal agricultural workers, public assistance recipients) have a lower average educational level than the State's population in general. Therefore, they have less knowledge of current health information, less knowledge of how to improve health practices, and less ability to contact existing health resources. In some groups, inability to read and understand English is an additional barrier to health education and use of services.
2. Some of these population groups (ethnic minorities, the aged) have substantial numbers of persons whose own cultural preferences have a greater influence upon their health behavior than any preference of the prevailing majority culture. They resist the techniques that modern health agencies consider essential for preventing and treating disease and promoting health.
3. Most of these groups have substantially lower average incomes than California families generally. With less income, they have less opportunity to purchase health counsel and treatment. They frequently feel that health resources (like other resources) are not accessible to them.
4. For some of the people in some of these population groups, residence is a handicap. Some persons live in counties with serious deficiencies of private and public health resources. Some persons (especially the aged and American Indians) live too far away from resources, or lack transportation, so that certain resources are not effectively used.
5. Eligibility requirements create many barriers to effective health care. The differences in the standards of eligibility in the public agencies of different counties are confusing as well as forbidding.

Fresno County has provided an instructive demonstration of how special health needs can be recognized and met. In 1949, a number of deaths in the families of seasonal workers in Fresno County focused attention on their health problems.(1) An intensive study at that time recommended:(2)

1. Decentralization of medical facilities;
2. Health services for itinerant agricultural workers to be provided on the same basis as qualified permanent county residents;
3. One nutritionist on the staff of each county health department;
4. Development of a program for making medical care available to agricultural workers on a statewide basis.

Early in 1951, the "West Side Clinics" were established in a chain through the isolated area thirty miles west of Fresno. Speaking some years after the development of the West Side Clinics, the Fresno County

Public Health Officer cited a drop in the infant death rate of nearly 50 percent in the years 1953 to 1955 in the area covered by the West Side Clinics, to whose services he gave much of the credit for this.(3) They assisted particularly in overcoming the great barrier of distance to established health facilities. They were geared to the cultural and educational level of the people served. Their preventive and early diagnostic work is said to have prevented many instances of expensive hospitalization. Lack of funds has been a major obstacle to further development of field outpatient clinics in Fresno County, as well as in other areas of the State.

Furnishing adequate medical care (preventive, diagnostic, curative and restorative) to the population groups with special medical problems is as much a local responsibility as it is a State responsibility. In some fields, the State is leading the way by evaluation of unmet needs, such as the recent study of seasonal agricultural workers carried out by Bruce Jessup, M.D. of the State Department of Public Health.(4) In some instances, the counties provide for care in the county hospitals, but the eligibility rules often keep out those who need care. Education is the important key—education of the groups in order that they may know what is already available and how to avail themselves of such services—and education of the population as a whole that they may be aware of the problems that exist around them.

REFERENCES

(1) Watt, J., Hollister, A. C., Beck, M. O. and Hemphill, E. C., "Diarrheal Diseases in Fresno County, California", *American Journal of Public Health* 43:728-741, June, 1953.

(2) California Governor's Committee to Survey the Agricultural Labor Resources of the San Joaquin Valley: Agricultural Labor in the San Joaquin Valley. Final Report and Recommendations. Sacramento, March 15, 1951.

(3) Monlux, Robert D., "Some Results of the West Side Clinic Program". Report delivered at the Western Branch American Public Health Association, Long Beach, California, May 1957.

(4) State of California, Department of Public Health, *Health Conditions and Services for Domestic Seasonal Agricultural Workers and Their Families in California.* Report and Recommendations. Berkeley, October 1, 1960.

Chapter 11

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Californians can take pride in the extent and quality of their health services. However, action must be taken now to maintain present levels of service in the face of increasing pressures on existing health resources.

The recommendations for immediate and long-range action presented in the Committee's report to the Governor were developed to secure the necessary services in the years ahead. Several important trends must be recognized:

1. The tremendous rate of population growth
2. The rising demand for more comprehensive health services
3. The declining per-capita supply of medical and allied personnel
4. The rise in unit costs of health services
5. The increasing difficulty of making complex and expensive new treatments available to all.

The Committee believes, in the best tradition of the health professions, that services must be available to all who need them. This goal can be achieved only if health services and their financing are organized with full consideration of these trends.

The Committee urges that councils be set up in various regions of the State (representing health professions, health facilities, and the public) for the purpose of planning and coordinating the health services of their own communities. A primary responsibility of these councils would be to develop plans for better location of new hospitals and related facilities.

Measures for the efficient use of all health resources, with special attention to good quality and reasonable costs, must be developed on a continuing basis at both State and local levels. Techniques must be developed for estimating and meeting future needs for health manpower, services, and facilities. The burden of filling the growing demand for health services will fall most heavily on private physicians and on private and voluntary hospitals. During the next fifteen years, the average patient load for California physicians will increase greatly. Immediate action is necessary to increase the future supply of health personnel, particularly physicians. Prompt expansion of existing medical, dental, and nursing schools is imperative, along with a program for establishing new schools.

The Committee recommends broadening the powers of the Boards of Medical and Osteopathic Examiners to permit disciplining of those guilty of incompetent or unethical practice and to establish higher standards of practice. A licensing and certification council would be established to coordinate the work of the various examining boards with one another and with the licensing of health facilities, and to bring the public interest to bear on these

activities. The membership of the council would include representatives of the health professions and the public.

The most practical way for the majority of Californians to provide for their own health services is by means of prepaid health plans. Additional sources of funds must be found to extend prepayment so that most of California's population will be protected in this way. The Committee has recommended several types of legislation designed to promote health insurance by extending voluntary prepayment.

More effective governmental medical programs can be developed if the State and local governments take joint responsibility for major State programs. Toward this end, the Committee recommends that administration of these programs be decentralized to the local communities, with State-wide program standards, with financing to be shared by State and local governments (except for costs met by federal funds). A single agency, or "one door," for referral to appropriate community services would encourage the coordination of local services. The State should also eliminate overlapping and duplication of its own programs.

Demonstration programs often point the way toward better and more economical methods of care. Such programs, which foster improved organization of health services, should be supported by State funds.

The people of California now spend more than two billion dollars a year for health services. About three-fourths of this total flows through private channels, including a substantial proportion through voluntary prepayment plans. About one-fourth is spent by governments. In addition, hospital facilities are purchased at the rate of $100 million per year, and tens of millions of dollars are spent annually for the education of physicians, dentists, nurses, and other health personnel.

During the next fifteen years, billions of dollars will be needed to expand health facilities and to educate additional personnel. Economical use of available funds is imperative. For example, an adequate State-wide plan for the location of new hospitals (as opposed to current uncoordinated building) could reduce hospital construction costs by as much as $650,000,000 between now and 1975. Costs could also be held down by reducing need for hospitalization through the full development of rehabilitation, organized home care, and hospital outpatient services.

Health services must keep pace with California's growing population. Health services must also meet new needs and overcome new problems. The next fifteen years can bring to the people of the State either superior medical care and improved health—or a crisis of unmet needs, lowered quality of care, and inflated costs. The Committee believes that the issue will be decided by the ability of associations and agencies responsible for health care to pool their knowledge and to cooperate in intelligent planning.

Appendix

PROPOSAL FOR REGIONAL HOSPITAL AND HEALTH PLANNING

An Act to amend Sections 431 and 1402 of the Health and Safety Code, relating to hospitals.

The people of the State of California do enact as follows:

Section 431.2 of the Health and Safety Code is amended to read:

431.2. The Governor shall appoint *a State* Advisory Hospital *and Health* Council to advise and consult with the department in carrying out the administration of this chapter. The council shall consist of the director, who shall serve as chairman ex officio, *the Director, State Department of Mental Hygiene* and eight (8) members, ~~*and shall include representatives of nongovernment organizations or groups,* and of state agencies, concerned with the operation, construction or utilization of hospitals, including representatives of the consumers of hospital services selected from among persons familiar with the need for such services in urban or rural areas. Of the members first appointed, four shall be designated by the Governor to hold office until October 1, 1948, and four shall be designated by the Governor to hold office until October 1, 1949.~~ *two of whom shall be licensed physicians in active practice, two of whom shall be hospital administrators, and four of whom shall represent industry, prepayment plans, labor, local government and other consumers of hospital services.* Members ~~other than the members first appointed~~ shall hold office for terms of two (2) years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed, shall be appointed for the remainder of such term. Council members, while serving on business of the council, shall receive no compensation, but shall be entitled to receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. The council shall meet as frequently as the director deems necessary, but not less than once each year. Upon request by four (4) or more members, the director shall call a meeting of the council.

Sections 431.5, 431.6, 431.7, 431.8, and 431.9 are added, as follows:

431.5. The Department, after consulting with and obtaining the advice of the State Advisory Hospital Council may establish hospital planning regions within the State.

431.6. Where hospital planning regions have been established, the Department shall appoint regional advisory hospital and health councils. Each regional council shall consist of the director or his designated representative who shall serve as chairman ex officio and twelve (12) members, three of whom shall be licensed physicians in active practice, three of whom shall be hospital administrators, and six of whom shall represent industry, prepayment plans, labor, local government, local health councils where they exist, and other consumers of hospital services. Members of regional councils shall be appointed for terms of four (4) years. Of the members first appointed, six (6) shall be designated to hold terms for two (2) years. Regional council members shall continue to serve until their successors are appointed. Any member appointed to fill a vacancy occurring prior to the expiration of a term to which his predecessor was appointed shall be appointed for the remainder of such term. Regional council members, while serving on business of the council, shall receive no compensation, but shall be entitled to receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. The regional

council shall meet as frequently as the director deems necessary, but not less than once each year. Upon request by six (6) or more members, the director shall call a meeting of the regional council.

431.7. Each regional hospital and health council shall advise and consult with the department in developing a regional plan for the orderly expansion of hospital and related community health facilities and health services to meet the long-range planning objectives of the region. In carrying out this function, the regional council shall:

(a) Review information on utilization of hospitals, related community health facilities and health services.

(b) Develop principles and standards of community need to guide hospitals, related community health facilities and health services in meeting needs of the public.

(c) Conduct public meetings in which professional groups and consumer groups will be encouraged to participate.

431.8. The Department, after consulting with and obtaining the advice of regional advisory hospital and health councils, the State Department of Mental Hygiene and other appropriate agencies, shall develop regional plans which will provide long-range programs to guide hospitals and related health facilities in meeting the needs of the regions effectively and without unnecessary duplication of facilities or services. Regional plans shall be revised and brought up to date annually.

431.9. When advised by the department that a proposed new hospital or proposed addition to an existing hospital is in conflict with the regional plan, the regional hospital and health council shall conduct a public meeting on the proposal in compliance with Section 1402 of this Code.

(Related to State Department of Public Health)

Section 1402.1, Health and Safety Code is added, to read:

1402.1. In hospital regions which have been established in compliance with Section 431.5 of this Code, the department shall determine to its satisfaction that each proposal for a new hospital or for the expansion of an existing hospital is in compliance with the regional plan. In reaching a determination on compliance with the regional plan, the department shall require the submission of verified information on the need, feasibility and character of the project and its relationship with the regional master plan. The department shall not approve a proposal for a new hospital or an addition to an existing hospital which is in conflict with a regional plan until the proposal has been considered by the regional council in a public meeting. When the regional council finds in a public meeting that a proposed hospital conflicts substantially with the regional plan, the council shall, within 60 days, conduct a formal public hearing on the proposal. The Department shall provide public notice of all regional council meetings and hearings. In public hearings, the regional council shall have the right to examine witnesses, including proponents of proposed projects under oath and to utilize the power to subpoena. In reaching its conclusions in public meetings and public hearings, the regional council will take into consideration all information submitted to the department relating to the proposal. At the conclusion of the public meetings and public hearings, the regional council shall make findings in relation to the need, feasibility and character of the project and its relationship with the regional master plan and suggestions for changes in the project to bring it into compliance with the master plan. Findings and suggestions of the regional councils shall be made public and shall be submitted to the proponent of the proposed project and to the department for its consideration.

(Relates to State Department of Mental Hygiene)

Section 5701.1, Welfare and Institutions Code, is added, to read:

5701.1. In hospital regions which have been established in compliance with Section 431.5 of the Health and Safety Code, the department shall determine

to its satisfaction that each proposal for a new hospital or for the expansion of an existing hospital is in compliance with the regional plan. In reaching a determination on compliance with the regional plan, the department shall require the submission of verified information on the need, feasibility and character of the project and its relationship with the regional master plan. The department shall not approve a proposal for a new hospital or an addition to an existing hospital which is in conflict with a regional plan until the proposal has been considered by the regional council in a public meeting. When the regional council finds in a public meeting that a proposed hospital conflicts substantially with the regional plan, the council shall within sixty (60) days, conduct a formal public hearing on the proposal. The Department shall provide public notice of all regional council meetings and hearings. In public hearings, the regional council shall have the right to examine witnesses, including proponents of proposed projects under oath and to utilize the power to subpoena. In reaching its conclusions in public meetings and public hearings, the regional council will take into consideration all information submitted to the department relating to the proposal. At the conclusion of the public meetings and public hearings, the regional council shall make findings in relation to the need, feasibility and character of the project and its relationship with the regional master plan and suggestions for changes in the project to bring it into compliance with the master plan. Findings and suggestions of the regional councils shall be made public and shall be submitted to the proponent of the proposed project and to the department for its consideration.

STATE GUARANTEE OF LOANS FOR HOSPITAL CONSTRUCTION

LEGISLATIVE COUNSEL'S DIGEST

Amends Sec. 22, Art. IV, Const.

Authorizes Legislature to lend credit of the State to insure or guarantee loans made by private lending institutions to nonprofit corporations to enable the latter to construct hospital facilities.

Assembly Constitutional Amendment No. ___.

A resolution to propose to the people of the State of California an amendment to the Constitution of the State, by amending Section 22 of Article IV (as amended November 4, 1952) thereof, relating to the guarantee by the State of loans for hospital construction.

Resolved by the Assembly, the Senate concurring, That the Legislature of the State of California at its 1961 Regular Session commencing on the 2nd day of January, 1961, two-thirds of the members elected to each of the two houses of the Legislature voting therefor, hereby proposes to the people of the State of California that the Constitution of the State be amended by amending Section 22 of Article IV (as amended November 4, 1952), to read:

SEC. 22. No money shall be drawn from the Treasury but in consequence of appropriation made by law, and upon warrants duly drawn thereon by the Controller; and no money shall ever be appropriated or drawn from the State Treasury for the purpose or benefit of any corporation, association, asylum, hospital, or any other institution not under the exclusive management and control of the State as a state institution, nor shall any grant or donation of property ever be made thereto by the State; provided, that whenever federal funds are made available for the construction of hospital facilities by public agencies and nonprofit corporations organized to construct and maintain such facilities, nothing in this Constitution shall prevent the Legislature from making state money available for that purpose, or from authorizing the use of such money for the construction of hospital facilities by nonprofit corporations organized to construct and maintain such facilities; provided, further, that *nothing in this Constitution shall prevent the Legislature from lending the credit of this State to insure or guarantee loans made by private lending institutions to nonprofit corporations to enable those corporations to construct hospital facilities;* provided, further, that notwithstanding anything contained in this or any other section of the Constitution, the Legislature shall have the power to grant aid to the institution conducted for the support and maintenance of minor orphans, or half-orphans, or abandoned children, or children of a father who is incapacitated for gainful work by permanent physical disability or is suffering from tuberculosis in such a stage that he cannot pursue a gainful occupation, or aged persons in indigent circumstances—such aid to be granted by a uniform rule, and proportioned to the number of inmates of such respective institutions; provided, further, that the Legislature shall have the power to grant aid to needy blind persons not inmates of any institution supported in whole or in part by the State or by any of its political subdivisions; provided, further, that the Legislature shall have power to grant aid to needy physically handicapped persons not inmates of any institution under the supervision of the Department of Mental Hygiene and supported in whole or in part by the State or by any institution supported in whole or part by any political subdivision of the State; provided further, that the State shall have at any time the right to inquire into

the management of such institutions; provided, further, that whenever any county, or city and county, or city, or town shall provide for the support of minor orphans, or half-orphans, or abandoned children, or children of a father who is incapacitated for gainful work by permanent physical disability or is suffering from tuberculosis in such a stage that he cannot pursue a gainful occupation, or aged persons in indigent circumstances, or needy blind persons not inmates of any institution supported in whole or in part by the State or by any of its political subdivisions, or needy physically handicapped persons not inmates of any institution under the supervision of the Department of Mental Hygiene and supported in whole or in part by the State or by any institution supported in whole or part by any political subdivision of the State; such county, city and county, city, or town shall be entitled to receive the same pro-rata appropriations as may be granted to such institutions under church, or other control. An accurate statement of the receipts and expenditures of public moneys shall be attached to and published with the laws at every regular session of the Legislature.

STATE INSURANCE FOR HOSPITAL CONSTRUCTION LOANS

LEGISLATIVE COUNSEL'S DIGEST

Adds Ch. 4 (commencing at Section 4403, Pt. 1, Div. 1, H. & S. C.).

Provides for state insurance of loans to nonprofit corporations for hospital construction purposes.

Limits types of loans eligible for insurance to those having terms of 25 years or less, bearing interest not in excess of an unspecified amount, and falling within a system of priorities established by the Department of Public Health for hospital construction. Also limits the amount of insurance to 75 percent of the estimated construction cost of the project for which the loan is sought, and the aggregate amount of loans which may be insured or insured in any one year.

Provides for administration of the program by the Department of Public Health, and authorizes the department to fix the terms, conditions, and amount of insurance for each loan.

Provides for payment of premium charge of one-half of 1 percent on principal of loans insured and for the deposit of the same in a new fund—the Hospital Construction Insurance Fund—to be used for the payment of administrative expenses and other charges.

Establishes the Hospital Loan Fund and continuously appropriates the money in that fund to the department to pay amounts owing on defaulted loans.

PRELIMINARY DRAFT

An act to add Chapter 4 (commencing at Section 440) to Part 1 of Division 1 of the Health and Safety Code, relating to insurance by the State of loans for hospital construction purposes, and making an appropriation.

The people of the State of California do enact as follows:

SECTION 1. Chapter 4 (commencing at Section 440) is added to Part 1 of Division 1 of the Health and Safety Code, to read:

CHAPTER 4. HOSPITAL CONSTRUCTION INSURANCE

Article 1. Definitions and General Provisions

440. This chapter may be cited as the "Hospital Construction Insurance Act".

440.1. Unless the context otherwise requires, the definitions set forth in this article shall govern the construction of this chapter.

440.2. "Department" means the Department of Public Health.

440.3. "Corporation" means a nonprofit corporation organized to construct and maintain hospital facilities.

440.4. "Hospital facilities" includes hospitals for the chronically ill and impaired and general, tuberculosis, and other types of hospitals and related facilities, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, diagnostic or treatment centers, and rehabilitation facilities.

440.5. "Construction" includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings.

440.6. "Lending institution" means any bank, trust company, savings and loan association, or other person or firm engaged in the business of lending money in this State.

440.7. "Project" means an undertaking by a corporation to engage in the construction of hospital facilities.

440.8. "Insurance" means an undertaking on the part of the State to guarantee repayment of a loan made by a lending institution to a corporation to enable the latter to engage in the construction of hospital facilities.

Article 2. Administration

442. The department shall administer the provisions of this chapter and shall adopt such rules and regulations as are consistent with law and reasonably necessary for the administration of this chapter.

442.1. Subject to the conditions set forth in this chapter, the department shall:

(a) Prescribe the terms and conditions of insurance issued under this chapter.

(b) Determine the amount of insurance to be issued with respect to each loan insured under this chapter.

(c) Require such reports and make such inspections as it finds necessary in connection with insurance issued under this chapter.

(d) Provide such methods of administration, appoint such personnel, and take such other action as may be necessary to comply with the requirements of this chapter and the regulations adopted pursuant to this chapter.

442.2. The department shall make a study of existing hospital facilities, including public, nonprofit, and proprietary hospital facilities, to determine the need for construction of hospital facilities, and, on the basis of such study, shall establish a schedule of priorities for the construction of hospital facilities for which insurance will be issued under this chapter. The department shall endeavor, in fixing this schedule, to develop a program for the construction of such hospital facilities as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all the people of the State.

Article 3. Application

444. Any corporation desiring to secure a loan to enable it to engage in the construction of hospital facilities may apply to the department for insurance in accordance with the provisions of this article.

444.1. The application shall be submitted to the department through the lending institution on a form approved by the department. It shall be accompanied by plans and specifications relating to the project, and shall contain:

(a) Information as to the need for the proposed hospital facilities in the area.

(b) A statement as to the prospective construction costs of the project and the financial feasibility of the project.

(c) Such other information as the department may require to enable it to determine whether or not repayment of the loan should be insured.

442.2. If regional advisory councils are established, a copy of each application shall be sent to the appropriate council, and no application shall be approved by the department unless it is consistent with the master plan for the region established by the advisory council having jurisdiction over that region.

Article 4. Eligible Loans

446. The aggregate amount of principal obligations of all loans insured under this chapter and outstanding at any one time shall not exceed _____, and the aggregate amount of principal obligations on all loans insured under this chapter in any one year shall not exceed _____.

446.1. The department shall not approve a loan for insurance under this chapter unless all of the following conditions exist:

(a) The project for which the loan is proposed to be made complies with state building standards for hospital facilities.

(b) The loan agreement contains a condition that the corporation comply with rules and regulations adopted by the department to insure that the project will be operated in a manner that is financially sound.

(c) Construction of the project is consistent with priorities established by the department under Section 442.2.

(d) The department finds that the revenues from the project will be sufficient to allow the corporation to meet its payments on the loan.

446.2. A loan insured under this chapter shall bear interest at such rate as may be agreed upon by the corporation and lending institution, but in no case shall such interest rate exceed ___ percent.

446.3. A loan insured under this chapter shall have a maturity not to exceed 25 years from the beginning of amortization and the loan agreement shall contain amortization provisions satisfactory to the department.

446.4. The amount of insurance on any loan insured under this chapter shall not exceed 75 percent of the estimated cost of construction of the project for which the loan is obtained.

Article 5. Fees and Charges

447. There shall be charged on each loan insured under this chapter a premium charge of one-half of one percent of the principal obligation of the loan outstanding at any time. This premium charge shall be collected by the lending institution and remitted to the department, and shall be deposited in the Hospital Construction Insurance Fund, which fund is hereby established. The amount in the Hospital Construction Insurance Fund, when appropriated, shall be used to pay administrative costs incurred by the department under this chapter, and to meet any other obligations which may be incurred by the State in connection with the insurance of loans under this chapter.

Article 6. Commitment and Default

448. Upon approval of an application for insurance, the department shall issue a commitment certificate to the lending institution setting forth the terms and conditions under which the loan will be secured. The certificate shall constitute a binding agreement of insurance on the part of the State on the terms and conditions set forth in the certificate.

448.1. In any case in which a corporation defaults on a loan insured under this chapter, the lending institution shall be entitled to receive the benefit of the insurance covering that loan. The department shall not, however, authorize payment until the lending institution assigns to it all claims that it may have on the loan against the corporation and any evidences of indebtedness, including a mortgage, which the corporation has executed with respect to the loan. The department shall take such action as may be necessary to enforce such claims, including sale or foreclosure proceedings. Any sums recovered under this section shall be deposited in the General Fund.

Article 7. Hospital Loan Fund

449. There is in the State Treasury the Hospital Loan Fund, all money in which is continuously appropriated to the department to enable it to meet obligations arising as the result of defaults on loans insured under this chapter.

Table 1

ADMISSIONS AND PATIENT DAYS
CALIFORNIA 1958-1959

CATEGORY	NUMBER		PERCENT		PATIENT DAYS PER ANNUAL ADMISSION
	Admissions	Patient Days	Admissions	Patient Days	
Total	2,014,004	43,499,483	100.00	100.00	21.6
General Hospitals	1,924,763	15,145,801	95.56	34.82	7.9
Acute-Short-Term	1,850,606	11,657,927	91.88	26.80	6.3
Tuberculosis	4,171	514,394	0.21	1.18	123.3
Psychiatric	25,000[a]	245,400[a]	1.24	0.56	9.8
Long-Term	7,000[a]	1,125,000[a]	0.35	2.59	160.7
Federal (Nonmilitary)	37,986	1,603,080	1.89	3.69	42.2
Tuberculosis Hospitals	6,707	1,287,547	0.33	2.96	192.0
Nonfederal	4,816	953,937	0.24	2.19	198.0
Federal (Nonmilitary)	1,891	333,610	0.09	0.77	176.4
Psychiatric Hospitals	51,534	20,841,135	2.56	47.91	404.4
Private	24,944	2,404,620	1.24	5.53	96.4
State	22,470	16,901,325	1.12	38.85	752.2
Federal (Nonmilitary)	4,120	1,535,190	0.20	3.53	372.6
Long-Term Facilities	31,000[a]	6,225,000[a]	1.54	14.31	200.8

[a] Estimates based on available information.

Note: Percents are rounded independently and may not add to totals.

Source: State of California, Department of Mental Hygiene, Statistical Research Bureau.
Journal of American Hospital Association, Hospitals, Guide Issues, August, 1959.
State of California, Department of Public Health, Bureau of Hospitals, California State Plan for Hospitals, 1960-1961.

Table 2

ESTIMATED BED NEED AND HOSPITAL CONSTRUCTION COSTS BASED ON PROJECTION OF EXISTING AND RECOMMENDED PLANNING RATIOS
CALIFORNIA, 1975

(Excluding Federal construction)

CATEGORY	BEDS IN USE AND UNDER CONSTRUCTION 3/15/60	PLANNING RATIO OF BEDS PER 1,000 POPULATION[1]	ESTIMATED BED NEED 1975[2]	BEDS TO BE BUILT BY 1975	CONSTRUCTION COSTS[3]
Total[4]					
Existing	142,444	9.5	240,350	97,906	$1,405,580,000
Recommended		7.5	189,750	47,306	755,370,000
Difference		2.0	50,600	50,600	650,210,000
General Hospital					
Existing	52,775	3.5	88,550	35,775	787,050,000
Recommended		3.0	75,900	23,125	508,750,000
Difference		0.5	12,650	12,650	278,300,000
Mental Hospital					
Existing	58,176	3.9	98,670	40,494	445,434,000
Recommended		3.0	75,900	17,724	194,964,000
Difference		0.9	22,770	22,770	250,470,000
Long-Term					
Existing	31,493	2.1	53,130	21,637	173,096,000
Recommended		1.5	37,950	6,457	51,616,000
Difference		0.6	15,180	15,180	121,440,000

1 Estimated California civilian population 14,960,000, July 1, 1959 by State Department of Finance.

2 Estimated bed need obtained by applying ratios to estimated California civilian population of 25,300,000 July 1, 1975.

3 Based on current 1960 estimate of $22,000 per general bed; $11,000 per psychiatric bed; $8,000 per long-term bed.

4 Total excludes 0.36 tuberculosis beds per 1,000 population. No additional tuberculosis facilities are proposed.

Note: Excluded are Federal facilities and construction costs.
Existing ratios are based on beds in use and under construction.
Recommended ratios are those suggested by Governor's Committee on the Study of Medical Aid and Health in California.

Source: State of California, Department of Finance, Budget Division, Population Estimates.
State of California, Department of Public Health, Bureau of Hospitals, California State Plan for Hospitals, 1960-1961.

Table 3

NUMBER OF FACILITIES AND BEDS IN USE[1]
BY CATEGORY AND TYPE OF OWNERSHIP IN CALIFORNIA
MARCH 15, 1960

CATEGORY	TOTAL (EXCLUDING FEDERAL)		STATE		COUNTY		DISTRICT		PROPRIETARY		NONPROFIT		FEDERAL NONMILITARY	
	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
Total	1,516	137,891	17	47,709	78	25,620	57	3,764	1,106	31,808	258	28,990	11	10,347
General	487	47,890	2	786	52	10,509	57	3,705	185	8,091	191	24,799	6	4,915
Tuberculosis	13	5,194	-	-	11	4,858	-	-	-	43	2	293	2	1,035
Psychiatric	183	43,144	11	35,550	-	816	-	-	167	6,340	5	438	3	4,397
Mentally Retarded[2]	139	13,242	4	11,373	-	-	-	-	135	1,869	-	-	-	-
Long-Term Care	694	28,421	-	-	15	9,437	-	59	619	15,465	60	3,460	a	a

1 Excludes beds under construction.

2 Includes facilities for emotionally disturbed children.

[a] Long-term care included in general facilities.

Note: Does not include military and institutional facilities.

Source: Journal of American Hospital Association, Hospitals, Guide Issues, Part II, August, 1960, pp. 384-385.
State of California, Department of Mental Hygiene, Statistical Research Bureau.
State of California, Department of Public Health, Bureau of Hospitals, California State Plan for Hospitals, 1960-1961.

Table 4

ESTIMATED COSTS FOR HOSPITAL INPATIENT SERVICES
CALIFORNIA, 1958-59

CATEGORY	ESTIMATED AVERAGE COST PER PATIENT DAY	ESTIMATED PATIENT DAYS	ESTIMATED TOTAL COSTS	PERCENT OF TOTAL COST
Total		43,499,483	$749,200,000	100.0
Nonfederal		40,027,603	685,200,000	91.46
General Acute		11,657,927	438,300,000	58.50
Community[1]	$40	8,854,653	354,200,000	47.28
County	30	2,803,274	84,100,000	11.22
Tuberculosis		1,468,331	23,600,000	3.15
Community[1]	17	73,865	1,300,000	0.17
County	16	1,394,466	22,300,000	2.98
Psychiatric		19,551,345	138,000,000	18.42
General Hospitals	30	245,400	7,400,000	0.99
State	6	16,901,325	101,400,000	13.53
Private		2,404,620	29,200,000	3.90
Short-term treatment	25	484,720	12,100,000	1.62
Long-term	10	1,489,200	14,900,000	1.99
Mentally retarded	5	430,700	2,200,000	0.29
Long-Term		7,350,000	85,300,000	11.39
Community[1]	12	4,400,000	52,800,000	7.05
County	11	2,950,000	32,500,000	4.34
Federal		3,471,880	64,000,000	8.54
General Hospitals	23	1,603,080	37,000,000	4.94
Tuberculosis	21	33,610	7,000,000	0.93
Psychiatric	13	1,535,190	20,000,000	2.67

[1] Community includes voluntary nonprofit, proprietary, city, hospital district, and University of California hospitals.

Note: Average costs per patient day are conservative estimates based upon available information. The total costs are rough estimates rounded to the nearest $100,000.

Source: Journal of American Hospital Association, Hospitals, Guide Issues, Part II, August 1, 1960.
State of California, Department of Public Health, Bureau of Hospitals, California State Plan for Hospitals, 1960-1961.

Table 5

HOSPITAL CONSTRUCTION, NUMBER OF BEDS BY CATEGORY
CALIFORNIA, 1950-1960

YEAR COMPLETED	TOTAL	GENERAL	TUBERCULOSIS	PSYCHIATRIC[1]	LONG-TERM
Total	64,813	28,148	1,408	17,828	17,429
Proposed[2]	11,206	5,975	70	1,886	3,275
1950	4,869	1,022	620	2,494	733
1951	5,491	1,395	62	3,129	905
1952	3,732	1,405	180	1,474	673
1953	3,360	2,011	-	532	817
1954	5,182	2,500	-	1,152	1,530
1955	4,041	2,634	293	114	1,000
1956	5,292	1,588	-	2,964	740
1957	3,286	1,850	18	110	1,308
1958	6,537	2,148	-	2,012	2,377
1959	8,353	3,582	49	1,861	2,861
1960*	3,464	2,038	116	100	1,210

* From January 1, to March 15, 1960.

[1] Excludes beds for mentally retarded and Federal facilities.
[2] Includes projects which have received grants of Federal and State funds, and other projects for which plans and specifications have been approved by the California State Department of Public Health as of March 15, 1960.

Source: State of California, Department of Public Health, Bureau of Hospitals, Hospitals for California, July, 1960.

Table 6

ESTIMATED GENERAL HOSPITAL BED NEED[1]
BASED UPON 75 PERCENT OCCUPANCY
CALIFORNIA 1950-1959

YEAR[2]	AVERAGE DAILY CENSUS	EXISTING BEDS	BEDS NEEDED 75 PERCENT OCCUPANCY	BEDS PER 1,000		ESTIMATED POPULATION[3]
				Existing	Need Based Upon 75 Percent Occupancy	
1950-1951	24,548	32,565	32,730	3.12	3.14	10,438,000
1951-1952	25,095	33,447	33,459	3.13	3.13	10,681,000
1952-1953	25,574	34,554	34,098	3.06	3.02	11,299,000
1953-1954	25,880	35,299	34,506	3.00	2.94	11,748,000
1954-1955	26,382	37,463	35,175	3.06	2.87	12,254,000
1955-1956	27,900	38,701	37,199	3.05	2.93	12,699,000
1956-1957	30,178	40,457	40,236	3.05	3.03	13,260,000
1957-1958	31,704	41,955	42,271	3.02	3.05	13,869,000
1958-1959	31,940	43,885	42,586	3.04	2.95	14,432,000

[1] Acute short-term beds only.
[2] Calendar year for community hospitals; fiscal year ended June 30 for county hospitals.
[3] July 1 estimate, beginning each fiscal year 1950-1958, State Department of Finance.

Source: State of California, Department of Public Health, Bureau of Hospitals Records.

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